Vol. XXVI. WINNIPEG, JANUARY 1930 No. 1

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The Canadian Nurse

A Monthly Journal for the Nurses of Canada
Published by the Canadian Nurses Association

Vol. XXVI. WINNIPEG, MAN., JANUARY, 1930 No. 1

Registered at Ottawa, Canada, as second-class matter.

Entered as second-class matter March 19th, 1905, at the Post Office Buffalo, N.Y., under the Act of Congress, March 3rd, 1897.

Editor and Business Manager:—
JEAN S. WILSON, Reg.N., 511 Boyd Building, Winnipeg, Man.

JANUARY, 1930

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Vol. XXVI. JANUARY, 1930 No. 1

Changing Views Relative to Mental Disabilities*

By C. B. FARRAR, M.D., Director, Toronto Psychiatric Hospital

It is possibly a pertinent question whether in these days psychiatrists, psychologists and mental hygienists take themselves too seriously; and whether the commodities which they severally or jointly offer to the public have been, in popular parlance, oversold. There can be no doubt that since the war, and in considerable part as a result of it, the attention of physicians, educators, industrialists, sociologists, and those interested in public welfare generally, has been focussed upon the subject of mental disease and deficiency as never before. Under such circumstances it is inevitable that there should be a good deal of unnecessary popularising of the mental sciences; and questionless numerous books and articles for general consumption have been written which had better not have been written. Self-elected authorities have sprung up all over the field to offer expert supervision and direction for all ages and conditions in life. The mental specialist assumes, or is assumed to have, the true explanation of children's tantrums, of the difficulties which result in adolescents leaving home, of unfortunate love affairs, of failure in business, of social rivalries and strife, of the nature of crime and vice, of strikes and industrial upheavals, of wars and revolutions, and possibly of the final separation of the sheep from the goats hereafter. One wonders how it has been possible for the generations that are gone to have endured and achieved without this intimate and continuous expert guidance.

On the other hand, it is surely one of the happiest results of the war that it contributed its bit to a viewpoint already taking shape, that much of the friction in life and many of its difficulties are really problems of mental hygiene.

Happily today we are not greatly concerned with arguments over the definition of "insanity." The use of the word has been abandoned in clinical psychiatry, and it has become purely a medico-legal term which in practice means little more than that the individual certified as "insane" may properly be placed under institutional treatment.

It is true that when the mental state of a person charged with crime is brought into question, the so-called tests of insanity are very precisely defined; but these tests, whatever ends they may serve in the courts, are quite useless for clinical purposes. It is to be understood, therefore, that a patient may be suffering from a mental disability, mild or severe, without necessarily being insane.

We start then with the premise that there are not, strictly speaking, two sharply defined and mutually exclusive conditions of mind which can be denoted by such pairs of descriptive terms as normal and abnormal, sound and unsound, "sane" and "insane"; but that we have to do rather with states which, compared with each other or with estimated averages, are "more" or "less" normal or abnormal, and that there are infinite gradations and transitions.

(*Address to the Alumnae Association, Toronto General Hospital School of Nursing.)

One may, nevertheless, set down certain terms to indicate arbitrarily the more conspicuous gradations as follows: Normal—Abnormal—Psychopathic—Psychotic.

Let us realise at once that it is impossible to give a definition of the *normal.* We cannot select any given person and postulate that his mental states and reactions constitute the pattern of normality. Neither is it possible to create a pattern of hypothetically normal behaviour. No two persons would agree on all of the details of such a pattern. All that normal can mean, then, is that it is average: the manner in which the reactions of a large number of people in ordinary health and of similar class racially, culturally, economically, as well as from certain other points of comparison, such as age and sex, tend to approach each other or to coincide, and to make up the composite which we call normal. From this point of view the mental life curve of each individual would appear as a somewhat wavy or irregular line, never the ideal straight line, wandering through a zone in the midst of which runs the mythical line of a hypothetical norm, sometimes nearing or blending with this line; sometimes zigzagging across it.

We conceive that such a zone must necessarily have boundary lines; but nature is not in the habit of setting up boundaries. They are always artificially constructed. No one may quarrel with us, therefore, if we deliberately draw at a certain distance on either side of the assumed normal straight line an arbitrary boundary and assert that a deviation which goes beyond this limiting line must be regarded as abnormal. Such deviation may be largely a question of degree, in which characteristics naturally present in the majority of people are signalised by their exaggeration or their deficiency. Again, the deviation may be marked by a modification or perversion of normal characters.

But *abnormal* states are ~~not neces~~sarily pathological. Many individuals far enough removed from the average in their manner of thinking and reacting as no longer to be classifiable as normal, are, nevertheless, quite capable of living their own lives, carrying on their work and fulfilling approximately their obligations. We may speak of them as unusual, peculiar or eccentric, without regarding them as distinctly morbid.

A degree further removed from the assumed norm is the group which we call *psychopathic.* Here we have to do as a rule with lifelong mental variants which tend to throw the individuals concerned out of harmonious relationship with their fellows, although one may not be justified in saying that a disease process is present. Again we find that we are considering degree transitions. Psychopaths are less able to make their way successfully through life than normal or mildly eccentric individuals, as they are more likely to run into difficulties in their social and industrial relationships, and to come into conflict with the law. They are also liable to exhibit from time to time considerable variations from their habitual state, which may make it necessary for them to seek treatment. Here we approach the border of the next group.

By *psychotic* conditions we mean definitely pathological mental states in the sense of a disease or process which is unlike the habitual normal state of the individual; or which may possibly represent the progressive aggravation of characters or trends not originally regarded as morbid.

The important point is that such a classification does not represent definitely delimited categories. There may be insensible transitions from one group to the next. It is merely a matter of convenience to recognise certain types regardless of the fact that they may merge into each other.

A popular distinction, which, however, hardly deserves credit in medical or nursing circles, is that between so-called "nervous" and so-called "mental" disabilities. Euphemistically all mild conditions are likely to be called nervous, and all severe conditions, including especially those in which there are evidences of violence of conduct and seriously distorted thinking, are apt to be called mental. In practice that is about all that the distinction means. It is a matter of degree. In this we are, of course, not referring to clinical differentiation of the various forms of neuroses and psychoses. The popular distinction appears to be largely for the purpose of avoiding the unpleasant implication of insanity which is supposed to be conveyed by the word mental. It may quite truly be said, nevertheless, that every nervous case is mental just as every mental case is necessarily nervous.

We encounter difficulties in psychiatry whenever we try to attach too specific a meaning to terms which are used for the convenience of description. We meet with this difficulty in the various classifications of mental diseases which have been put forward from time to time. The arbitrary naming of mental diseases and the endeavour to recognise in each a more or less definite symptomatology has tended to give an altogether one-sided view of pathological mental states.

The major varieties of reaction, whether normal or morbid, are not unlimited in number and there are a few pathological types which recur with considerable regularity. On the other hand, a given case is quite as likely as not to fail to agree with any preconceived picture; and it is probably true that every case will present individual deviations not conforming to any pattern.

It has become common practice, therefore, to speak of types of *reaction,* several of which may be combined in one patient without necessarily dignifying any of these varieties of response with the name of a *disease.* We find adjectives much more useful than substantives in this connection.

There is something of finality in the situation when we assert that a patient has this or that disease; but, unfortunately, in the clinical differentiation of mental states the idea of finality is often singularly inappropriate. To the assumed disease we assign assumed characteristic symptoms, and in scrutinising the disease we may all but overlook the patient.

When in the family circle one member presents evidence of mental disease the immediate question is naturally what treatment procedure to follow. The other perplexing question continually forcing itself to the front is how did such a situation come about. Let us look at the second question first. The anxious relatives seem to feel oftentimes that one should be able in a few words to answer this question of causes. As a matter of fact, assuming that the necessary information was available, it would probably take several hours of continuous discussion to account adequately for the abnormal reaction the patient presents. An understanding of the case presupposes comprehensive, even detailed knowledge of the life history of the individual, not merely what illnesses or accidents he has had, but what has been the type of his daily life and experience throughout the various phases of his career to date.

Possessing this information we can say of certain patients: they have not *become* so, they simply *are* so. That is, the exaggerated kind of reaction which we now look upon as disease is nothing more nor less than a combination of the normal, or, as we say, constitutional characteristics of the individual, exaggerated perhaps, or in some way modified by the conditions of life.

More and more in the thorough-going study of cases we are forced to the view of the constitutional nature of mental disease; that is to say, the mental sets and trends transmitted from the ancestral line together with such modifications or acquired characteristics as develop during the early formative years of life. In some cases the theory of constitution appears to account for all or nearly all of the clinical manifestations of a psychotic patient; and the morbid potential which has become manifest is simply evidence of a deficiency or disharmony of some kind in the development and personality integration of the individual.

Persons showing what is spoken of as of the hypomanic constitution offer a good illustration of the situation here referred to. Such persons are by nature and temperament excitable, emotionally unstable, perhaps quick to anger, or inclined to be flighty and erratic. These and other traits of this constitutional type may under stress become accentuated and we have an acute manic outbreak lasting some weeks and subsiding. During the psychotic phase it may be possible to derive most of the symptoms from habitual characteristics; and following the attack when the patient has returned to his individual norm it is similarly possible to discern, written small, the characteristic features of the preceding attack.

But in our scrutiny of constitutional tendencies we must not lose sight of the other aspect of mental disorder, namely, its reactive character. It is a commonplace to say that our daily life consists of a succession of reactions to stimuli. The balance of health depends to greater or less degree upon the nature and intensity of the stimuli. It is not difficult to understand that unfavourable stimuli may produce morbid reactions. Even the strongest constitution may give way under unusual stress. While, therefore, in certain psychoses we see mostly the evidence of constitutional predisposition, in others we are obliged to attach major importance to the circumstances and conditions under which the patient has been living. But even in these latter, with possible rare exceptions, it is necessary to invoke also the constitutional factor in order to account wholly for the disease process which has supervened.

Having now such information as it is possible to obtain concerning the personality type of the individual and his reactions as determined by the accidents of life, we are faced with the more important question, namely, what is to be done about it.

It is unfortunately too often true that when the adult comes under treatment for a mental disability, presumably of somewhat recent origin, inquiry shows that he is suffering from a condition, the seeds of which were planted in childhood, if indeed he did not come into the world with them. What has attracted attention as the onset of a mental disorder has merely been the proverbial last straw; and the morbid changes in conduct simply corresponded to the break in compensation. By this time unwholesome trends and dishygienic mental habits of all kinds have become well established, and the difficulties of the problem are at once apparent.

The first right of every individual is to be well-born; and society should guarantee the equally important right not to be born at all if he cannot be well-born. Unfortunately, the subjects of eugenics, sterilisation and birth control often raise prejudiced and emotional discussions in which dispassionate reasoning plays no very great part. Traditions and taboos, the heritage of centuries, which may have no other arguments to support them than their very age, still operate to hinder wholesome and logical procedure in the life and conduct of human beings, while in most other fields of action they have long since lost their binding force. The human being is, however, one of the manifestations of nature and no plan of human welfare can be satisfactorily effective unless it endeavours to promote the production of sound individuals and to prevent the reproduction of the obviously unfit. When one realises that patients in hospitals for mental diseases and deficiency outnumber all those in other hospitals combined, and that in a large number of cases the only suitable treatment would have been the prevention of their birth, the significance of radical prophylaxis becomes startlingly apparent.

It is a long story of many chapters, that of the developing mind of childhood and adolescence, of wholesome home relationships, influences and direction, of intelligent school discipline, of suitable social contacts and favourable living conditions generally; or, on the other hand, of the reverse of any or all of these things. It is a field which today is being assiduously cultivated by many workers. Indeed, there is the possibility that here and there some enthusiastic worker may be overdoing the matter. There are two facts which must be kept in mind and balanced skilfully against each other.

The first fact is that mental disorders appear during childhood in embryonic forms, and, in some cases, at least are susceptible to modification or correction. Such conditions if neglected may result in lifelong handicap, if not in serious, even permanent, disability. The knowledge that these deviations may be discernible at an early age and may yield to favourable influences is of the greatest possible significance from the standpoint of prophylaxis, especially when it is recalled that not so long ago mental disease was looked upon as essentially incidental to adult life.

The other fact, however, must not be lost sight of, namely, that childhood is the period when we must not expect too rigid conformity to standard and pattern, and when some allowance must be made for individual variations, even extravagances of conduct, which will become satisfactorily equalised and balanced during the maturing process. Remembering that many of the so-called conduct disorders of childhood are almost wholly artifacts, natural or inevitable reactions to conditions not of the child's making, it is not always necessary to attach too much importance to the manifest symptoms as if they represented an inherent mental abnormality. The problem, therefore, is to distinguish between essential or constitutional syndromes and those which may be accidental or temporary in character, and to adopt measures accordingly.

Obviously the habits of thinking and feelings which the child forms will be continued in adult life. What assurance can we have that children, whose name is legion, who have neither guidance nor example in the most wholesome exercise of their mental faculties, will as adults find themselves equal to the daily demands upon judgment and self-management by means of which mental health and equilibrium are maintained?

A little girl was asked why she went to school.

"To learn," she replied.

"To learn what?"

"To learn geography and arithmetic and history and—and things."

Is there not in that snatch of conversation a serious lesson for pedagogy? Are children not taught too many "things" and too little thinking? The majority of children do not enjoy the benefits of higher education. They do not receive instruction in psychology, logic and the art of thinking straight. Adults in amazing numbers are quite innocent of the most rudimentary principles involved in drawing logical conclusions, in weighing premises and forming rational judgments, in distinguishing opinions or beliefs motivated by an emotional state from those derived by process of reasoning. In the examination of a mental patient we may be struck by the apparent absurdity of his beliefs. He may entertain a delusion which seems singularly illogical and bizarre; and we wonder at it. We find his opinions, however, comparatively less strange when we reflect upon the credulities of everyday life among presumably normal people.

Loose, inconsequential, non-logical thinking is one of our besetting sins. It leads us not infrequently into minor blind alleys as a matter of course and sometimes into more serious ones which turn out to be actual mental disabilities.

In time perhaps mental hygiene will be a part of the regular curriculum in the public schools, no less important than the three R's. It should not seem visionary to insist that children should be trained in the ways of straight thinking, not only as an indispensable part of their educational equipment but as a potent prophylactic against mental invalidism in later life.

These are some of the leads offering hope of progress in one of the most perplexing fields in medicine. It is a very encouraging thing that nursing organisations are turning their attention to the value of mental hygiene and psychiatry as a part of the regular training courses.

There are two reasons for this increasing interest on the part of the nursing profession. In the first place, they are aware of the greatly widened scope of psychiatric nursing as such. Mental diseases no longer mean merely the occasional cases committed to institutions for long periods of treatment, but include a great variety of disabilities, often minor so far as conspicuous symptoms are concerned, but none the less serious as social or economic handicaps. Such disabilities are common. They are met with in every-day medical and nursing practice, and to deal with them requires special training just as much as in the case of tuberculosis and surgical conditions or any other particular field.

But there is another reason which emphasises the importance to the general nurse of experience in dealing with nervous or mental patients. The time is past when diseases were treated merely as disease, the patients being so many cases. It is the individual patient as a unitary organism functioning as a whole which we have to consider now in every illness of whatever kind. In a case of physical disease it is of prime importance to know the patient's subjective state. What is his attitude toward his disease? Does he take it too seriously or not seriously enough? Is he normally hopeful, or abnormally discouraged, or indifferent? Has he the will to get well? What is his attitude toward doctor or nurse, and the measures they are taking in his behalf? Does he show evidences of confidence, suspicion or fear? What cooperation does he give in the necessary means of treatment?

These are all question which indicate the wholesome or unwholesome mental state of the patient, which obviously has a very direct bearing on the progress we may expect him to make. They are merely common-sense questions, but they are also psychiatric questions; and it is worth while remembering that there may be, in however mild a degree, a psychiatric element in any physical disease. At any rate, every patient should be considered from the dual viewpoint, that of the physical condition which may first demand attention, and also that of the patient himself as a thinking, feeling individual. The best way to acquire this all-round manner of looking at illness is to include in the work of the nurse in training experience with a sufficient variety of patients whose disabilities are not primarily physical but mental.

In a considerable number of training schools this end has already been accomplished. In the training school at Yale University, the first university to appoint a professor of psychiatric nursing, there is a two months' affiliation course given at Butler Hospital, where pupil nurses are in residence for that period. During this time there are thirty-two hours' lectures and six hours' conferences in psychiatry, eight hours' lectures and thirty-eight hours' demonstrations in psychiatric nursing, including occupational therapy and hydrotherapy. These courses follow a thirty hours' lecture course in general psychology.

At the Phipps Psychiatric Clinic in Baltimore, nurses in training at the Johns Hopkins Hospital spend ten weeks during their senior year. This work follows twenty-two hours of lectures and demonstrations in the intermediate year, covering psychiatry, neurology, mental hygiene and psychiatric nursing. During the senior year members of resident staff hold two conferences weekly for student nurses.

At the Boston Psychopathic Hospital a three months' affiliation course is given. At present seven accredited general hospitals participate, each hospital guaranteeing to send a specified number of student nurses for three months. In addition to practical ward work in the various services, including two weeks of night duty, there are ten hours' lectures in preclinical subjects, including psychology and physiology of the nervous system, twenty hours' lectures in clinical psychiatry and mental hygiene, twenty hours in clinical demonstrations at staff conferences, sixteen hours' attendance at ward clinics, sixteen hours' lectures and twenty-four hours' demonstrations and practice in psychiatric nursing, including hydrotherapy, twenty-four hours in occupational therapy, four hours in psychometrics and fourteen hours in outpatient clinics and social service.

Affiliation courses are also provided in various hospitals in the New York State Service, which follow very much the lines already indicated.

The lively interest which the Registered Nurses Association of Ontario has manifested in the subject of mental hygiene and psychiatric nursing for pupils in training in general hospitals leads us to hope that plans may early be worked out whereby affiliation courses may become available similar to those in other parts of the country. With the progressive development of training schools the scope of the work has steadily increased, corresponding with the expansion of the special fields of medicine. The inclusion of mental hygiene, with actual service in psychiatric clinics, will constitute a further and most important step in rounding out the already excellent training courses now given. It will prove of material benefit to both the general and special hospitals concerned, and will play an important part in bringing into more intimate contact, as is so urgently desirable, the disciplines of general medicine and psychiatry from the standpoints of medical treatment and nursing procedure.

To go through this world without aim or direction, without any definite goal or knowledge of self, and with no fundamental principle to steady and guide and inspire us, is little less disastrous in its results than a man who should launch his vessel upon an unknown and uncharted sea, and allow himself to be drifted whither the winds and waves carried him, with no safe anchorage. . . . One of the reasons why life for so many of us is drab and humdrum is simply because we do not leave enough room in it for adventure—for experimenting and taking risks.

"The World Without and Within,"
By THEODORA THOMPSON.

Editorial

The season of the year in which many happy memories are revived by everyone has come and gone. *The Canadian Nurse* joins in wishing its readers a year of health and professional prosperity and development.

We sometimes wonder if, as nurses of Canada, we pause long enough and often enough to recall that we are living in the epoch-making days of a country which has a future ahead so great that it is quite impossible for anyone to foretell or comprehend what developments are to take place even within the next ten years—years in which many who read this will be giving their best to the nursing profession.

As we consider the opening up of our broad Dominion, and recall the arrival of the first French nursing sisters on the shores of New France almost three hundred years ago, we are reminded that as each new district is opened up, the essentials are: first the road, then the school and church, then the nurse. For a time the nurse was slow in coming, but in the last quarter of a century there has been an awakened consciousness of the importance of the nurse. Now she is wanted as a teacher of health as well as to minister to the sick and suffering. This new demand called for a new type of nurse with special preparation, and our Canadian universities quickly came to the assistance of the schools of nursing.

Only ten years ago our nurses were given the first opportunity to obtain post-graduate experience and education through our Canadian universities; today, seven universities between the Atlantic and Pacific coasts are open to our nurses. No doubt other institutions will open their doors as soon as it is evident that there is sufficient demand for them to do so.

Each year there is an increase in the number of scholarships offered. Nurses' organisations, especially Alumnaes, which undertake to provide scholarships, are highly commended for that type of contribution towards the education of the nurse. We have waited long for individuals to contribute in this way; however, the splendid generosity shown in the Crowe Scholarships tends very much towards establishing confidence that others may be announced later on.

The institutes and refresher courses have helped tremendously in stimulating nurses to seeking these sources for assistance.

The interest shown by the secondary schools in co-operating with nurses' organisations for finding means whereby these schools can aid in assisting with nurses' education is a most marked indication of the trend towards better education for the nurse.

The teaching faculty, or staff, in the schools of nursing is becoming better organised and educated for its special purpose. The head nurses and ward supervisors are awakening to their need for development and to their important rôle in the school.

All these are indications of progress which should tend towards encouraging us as the past is reviewed, even though that same past reveals many failures and disappointments. We profit by these, and as the present is faced and the future anticipated, we should be able to assure ourselves that nothing is to be feared, and everything dared, as long as professional education and obligations continue to be held high by each one.

Canada Looks at the Neighbours

By ETHEL JOHNS

Since Canada has just embarked upon a Nursing Survey of its own, it might be of interest and profit to Canadian nurses to look at what their neighbours, more or less distant, are doing.

There seems to be a general impression that the United States, in addition to being the Land of the Free and the Home of the Brave, is also the exclusive haunt of the Survey. One observer is inclined to think that, so far as nursing surveys are concerned, this is far from being the case. During the last five years her job has brought her into fairly close contact with nurses and nursing in Great Britain, the Irish Free State, eight European countries, the United States and Canada. While it is not true that surveys, in the strict interpretation of the term, are taking place in all of them, nevertheless a questioning spirit is abroad, and a desire to know what nursing is and where it is going. In Hungary, in Roumania, in Italy, for example, that question is being asked by high government authorities and an attempt is being made to answer it. In other words, an informal inquiry is going on upon which eventual nursing policies will be based.

The English are notoriously averse to self-analysis and surveys leave them cold, and yet a nursing survey has been made recently in England. It was conducted by a committee sponsored by the Labour Party, not then as now, in power. The writer had the privilege of being present at the meeting when its findings were announced before a representative gathering of hospital administrators, matrons, physicians and nurses. This survey was especially interesting because it had been organised and carried on chiefly, though not altogether, by lay people. It had a certain objectivity which set it apart from studies which are more or less strongly tinged with the professional point of view. It was taken seriously by the political party which initiated it. Mrs. Sidney Webb presided, and Mr. Ramsay MacDonald gave the introductory address. Its report, while probably open to challenge on a good many points, bore evidence of sincere study and careful preparation. The main contentions were that there was exploitation of student nurse labour in English hospitals and that the system of nursing education in vogue was not altogether satisfactory.

The Labour Party had perhaps expected that there would be a lively discussion and that the hospital authorities would defend their position. Nothing of the sort occurred. The hospital authorities, including the redoubtable Lord Knutsford, looked mildly bored and said nothing. The meeting proceeded to its close in the usual decorous British fashion.

An American observer would perhaps have concluded that the whole thing had fallen flat, and to a certain extent he would have been right. Nevertheless, that survey accomplished something. It created a questioning attitude among the group which was under fire. It set the professional situation in a new light and invited study from the lay point of view. Perhaps a survey which does just that and nothing more has not been made altogether in vain.

Let us now examine the work done in the United States by the Committee on the Grading of Nursing Schools.

It will be remembered that this committee consists of representatives of the following professional groups:

1. The National League of Nursing Education.
2. The American Nurses Association.
3. The National Organisation for Public Health Nursing.
4. The American Medical College.
5. The American College of Surgeons.
6. The American Hospital Association.
7. The American Public Health Association.

These representatives added to their numbers six members at large, representing the fields of general education, the public and the general practitioner. May Ayres Burgess, Ph.D., an able statistician and trained investigator, was appointed director. In November, 1926, she submitted a five-year programme and a budget. The estimated total cost for the five years' study is two hundred thousand dollars, and the committee's task will probably be completed at the end of 1931. The very name of the committee indicates that its ultimate purpose is far broader than that of merely making a survey. Nevertheless, a very comprehensive survey has been made. So comprehensive, indeed, that it fills a book of 618 pages, entitled Nurses, Patients, and Pocketbooks, written by the director of the committee. Perhaps Dr. Burgess herself would agree that, in the last analysis, she did not write this book. It was written by the nurses, the patients, the doctors themselves, then, by a miracle of patient research and skilful compilation, Dr. Burgess transformed a number of very human documents into a searching statistical study. Canadian nurses will do well to examine carefully the statistical tables and diagrams in Dr. Burgess's book. They shed the light of cool reason on certain basic nursing problems which, to some extent at least, are common to both the United States and Canada. Discussion of these problems has, in the past, been apt to produce more heat than light. A more scientific approach can do no harm and may do good. After all is said and done, a survey is, or should be, a co-operative undertaking in which the surveyed play a part quite as important as that of the surveyors. There should be no feeling of resentment at being asked for information, and yet unless the questions are skilfully and tactfully put, there sometimes is. The work of the Grading Committee has been greatly facilitated because it has taken the trouble to try to create a sort of psychological atmosphere which makes for mutual understanding. Nobody likes answering questionnaires. They have a habit of arriving on the morning when one is engaged in trying to find a night nurse for Ward D, or wondering why in spite of one's best preventive methods there are still a large number of positive swabs in the district, or—worst of all—when one has just come off a twenty-four-hour case. Yet, without questionnaires it is almost impossible to assemble the necessary statistical data upon which any survey which is worthwhile must be based. We should remember that Florence Nightingale herself was not only a nurse but also a "passionate statistician." In a letter to Professor Jowett she writes almost despairingly, "We legislate without knowing what we are doing." Nothing so outraged the closed minds of the army physicians of her day as her relentless compilation of statistical data. Nothing so effectively carried conviction even to the most stubborn of them.

It is evident that the Director of the Canadian Survey is fully aware of the importance of assembling a body of information from which accurate conclusions may be drawn. It is possible that the questionnaire may be one of the means he will use to this end. It is to be hoped that, at the conclusion of his task, he will be able to pay the same tribute to his nurse collaborators as we find in the concluding paragraph of the foreword to Nurses, Patients, and Pocketbooks: "Because the questionnaire method makes possible the gathering of statistical data and personal testimony in a variety, quantity, and representative quality almost unavailable through any other device, it has become extremely popular, and is being used for many purposes by many different investigators. The result is that busy people are bombarded with questionnaires; and sometimes are strongly tempted to toss each new appeal of this sort into the waste basket unanswered. Had all the people who received questionnaires from the Grading Committee yielded to that natural human impulse, Nurses, Patients, and Pocketbooks could never have been written. Consequently, every individual who took the time and trouble to send back a completed questionnaire to the committee may with full justice regard himself as field agent of the committee and contributor to the book. To each of them the committee, and the author, owe a special vote of heartfelt thanks."

It is, of course, far too early to appraise the ultimate results of the Grading Committee's work. Its task is not nearly completed. But here is the interesting feature of the whole situation. Certain results are already apparent. Perhaps they have come about as the first fruits of that questioning spirit which, apparently, a survey tends to create in any country. It happened in England. It is happening in the United States. It is reasonable to suppose it may happen in Canada.

It would be premature to do more than indicate what some of the leaders of American nursing think is already taking place. Perhaps it is safe to say that schools of nursing, even large ones, seem to be regarding themselves more critically and less complacently than they once did, and that hospital boards of management are facing the economic problems associated with nursing service more squarely than in the past. The private duty nurses are giving earnest and constructive thought to the unemployment which exists in their ranks and the hope of an improved registry service is in the air. The medical press is publishing more and better articles on nursing service than ever before. No doubt other factors than the work of the Grading Committee have contributed to this marked improvement in the nursing situation. But that its work has already had a profound influence no unprejudiced observed can deny.

The Canadian Survey is proceeding, as it should proceed, under Canadian direction, and with its programme and policies adjusted to the national needs. Its methods of approach, its conclusions, its recommendations may, and probably will, be widely different from those in other countries. In spite of these differences there subsists one important common factor. Surveyors and surveyed must co-operate in the common enterprise, even if it means answering questionnaires.

One might perhaps venture to hope that in Canada as in other countries an intelligent, unprejudiced study of nursing service may not only lay a sound foundation for future policy, but, even in its early stages, pave the way for the reforms which are its ultimate goal.

THE SURVEY

Readers of "The Canadian Nurse" are no doubt anxiously waiting for news of the progress of the Survey of Nursing Education in Canada, which has at last been begun by Dr. George M. Weir, Professor of Education, University of British Columbia.

At the request of the Joint Committee of the Canadian Medical Association and the Canadian Nurses Association, Dr. Weir has begun his work in Ontario. This starting point was decided on for two reasons—first, because it seemed desirable that at the outset Dr. Weir might be closely in touch with the members of the Committee; also, because of the fact that there are many training-schools in hospitals of various kinds within easy travelling distance of Toronto, it was felt that the Director whose leave of absence from his University is limited, might make a concentrated attack with the minimum loss of time. After Ontario, the Director will probably spend some time in Quebec and the Maritime provinces, then in the Prairie provinces and British Columbia.

During the first two months of the Survey, Dr. Weir has been laying the foundation for the Study of Nursing in Canada.

In addition to the preparation of ten special questionnaires, Dr. Weir has held conferences and interviews, has made visits to hospitals, has attended lectures, demonstrations, etc., for observation of methods of teaching student nurses and has given psychological examinations to three hundred student nurses. Based on these examinations, a prognostic study has been made regarding leadership and possible success of a nurse.

A community study regarding the nursing needs of the family of average means has been organised in a general way. This study has been carried out in co-operation with the Social Service Department of the University of Toronto.

A study of the following is being organised: curriculum, examination standard, the cost of nursing education and the educational and economic features of the centralised lecture plan.

Over one hundred letters have been returned to the Director's office, owing to faulty addresses of registered nurses supposed to be resident in Ontario. All nurses in Ontario who have not received a questionnaire inviting them to participate in the Survey should write the Director, 1 Queen's Park, Toronto 5, stating the branch of the profession to which they belong, and a questionnaire will be forwarded at once.

It is necessary that all registered nurses should support the Survey by taking an active part if the results anticipated from the Study of Nursing Education are to be realised.

At a later date, opportunity will be given for nurses in the other provinces similarly to participate in this study. Results of the investigation throughout the Dominion will then be integrated and interpreted.

MISS MARGARET BREAY HONOURED

Canadian nurses will be greatly interested to learn that the first Fenwick Gold Medal of Merit has been presented to Miss Margaret Breay, F.B.C.N., Vice-President of the British College of Nurses.

The presentation, which took place at the opening meeting of the winter session of the College, was made by Mrs. Bedford Fenwick, friend and colleague of Miss Breay in the nursing profession for over forty years.

Miss Breay, a graduate of St. Bartholomew's, spent several years as Matron of the English Hospital at Zanzibar, and following her return to England she became interested and active in the struggle for State Registration of Nurses. She also became Assistant Editor to the British Journal of Nursing, and still remains as Honorary Assistant Editor. Miss Breay, who has held many offices in nurses' organizations, is a Foundation Member and Councillor of the International Council of Nurses, Honorary

Treasurer of the Council for 21 years, and an Honorary Member since 1925. Miss Breay was also presented with a lovely sheaf of golden chrysanthemums.

Canadian nurses in offering their congratulations to Miss Breay join with their sister nurses of England in wishing that she may feel able to continue in the profession which she has served so well for many years.

INTERNATIONAL HYGIENE EXHIBITION

Dresden, May to October, 1930

The approaching date for the opening of the new building for the German Hygiene Museum in Dresden—which has been in existence since the days of the 1911 International Hygiene Exhibition in that city—has brought to maturity the plan of presenting once more, as in 1911, a true picture of present-day knowledge of hygiene and its results, in the form of an exhibition, which will also serve to show the work of the Museum.

When the preliminary work for the "International Hygiene Exhibition, 1911," was taken up by its originator, Lingner, the Dresden industrial magnate, and the co-operation and support of public authorities and experts were desired, Lingner expressed the ardent desire that the exhibition should be an enterprise with higher aims than were usually found in exhibitions. The ideal purpose, to enlighten the population in hygiene and to give a thorough idea of what had hitherto been accomplished in the field of hygiene, was to stand exclusively in the foreground, and, bearing these points in mind, it was thought that the most effective method of educating the public in hygiene was by the formation of an exhibition. Its object was not only to make on the visitor a lasting impression, and urge him to take better care of his health, but also to be the starting point for a movement to create opportunities everywhere for permanent instruction in hygiene, and the International Hygiene Exhibition, Dresden, 1911, realised the ideals for which Lingner had hoped.

The Deutsche Hygiene-Museum, an outgrowth of the Dresden International Hygiene Exhibition, 1911, has continued the work of enlightenment then commenced, and gained world-wide fame, particularly by its activity in the sphere of travelling exhibitions at home and abroad. Indeed, it was the fine Exhibition of 1911, together with the valuable work of the Deutsche Hygiene-Museum, that cleared the way for popular education in hygiene and the pointing out of new methods.

Thus, the Deutsche Hygiene-Museum has developed in the course of years to a central institution for public hygiene. Its importance for the improvement of the health of the people is generally known. In Germany and numerous other European countries (Denmark, Sweden, Norway, Finland, Holland, Luxembourg, Switzerland, Austria, Czechoslovakia, Hungary, Latvia) its influence has been beneficial, and the Health Section of the League of Nations has also availed itself of its help in procuring instructional material for medical training in Moscow, Charkow and Warsaw.

A worthy home is now being erected for the Deutsche Hygiene-Museum on a beautiful central site in Dresden, in the immediate vicinity of large athletic fields (Stadium) of the "Grosser Garten" and of the Dresden Exhibition district. The foundation-stone was laid on October 8, 1927, and exactly one year later, on October 8, 1928, the roof was set up. In the autumn of 1929 the new building was occupied, and in the beginning of May, 1930, the Deutsche Hygiene-Museum will open its doors to the public. For the first time a number of new groups can be shown, representing both the latest scientific researches and the development of exhibition technique.

The extensive "Exhibition for Hygiene, Social Welfare Work, and Physical Culture, Düsseldorf, 1926," to which the Deutsche Hygiene-Museum made vital contributions by displaying important groups, particularly the "Man" series, was the work of the well-known children's specialist and organiser, Geheimer Medizinalrat Professor Dr. Schlossmann. In a perfection that can hardly be attained again, there was specially represented the sphere of private and public welfare work. Dresden, on the other hand, in its Exhibition will not deal uniformly with everything relating to hygiene, social welfare work, and body training, but, in accordance with the idea of "quality" governing the Dresden exhibitions, the closely defined spheres of *Personal Hygiene and Physical Culture,* which received comparatively little attention at the "Gesolei" exhibition, will form the principal part of the Exhibition planned in Dresden for 1930.

The German Reich, the Free State of Saxony and the city of Dresden are co-operating with the Museum for the organisation of the Exhibition. A great number of foreign countries will participate in the Exhibition as well as a number of international organisations, including the League of Nations and the International Labour Office. The International Council of Nurses will also take part in the Exhibition, partly through material sent from the national associations of nurses and partly by means of statistical material of a comparative character collected by its headquarters in Geneva.

Apart from the Museum itself, the Exhibition will be divided into different departments, such as, for instance:

General Care of the Body.
Physical Exercises.
Occupational Hygiene.
Food.
Clothing.
Dwellings.
Popular Hygiene Instruction.
Special Exhibit: "The Hospital."

It is in the last two mentioned that nurses will take part.

(Note: Received from Headquarters, International Council of Nurses.)

HEALTH CONFERENCE OF VOLUNTARY ORGANISATIONS

A most important forward movement in relation to health problems and development in the Dominion of Canada took place when on invitation from the Hon. Dr. King, Minister of Pensions and National Health, representatives from fourteen national voluntary organisations in the Public Health field met on November 28th and 29th, 1929, at Ottawa.

The Canadian Nurses Association was represented by Miss G. M. Bennett, Second Vice-President, Canadian Nurses Association, and Miss G. Garvin, Chairman of District No. 8, Registered Nurses Association of Ontario.

Dr. King, in his address, outlined the degree to which the Canadian public was indebted to the organisations represented in the conference for the high standard of public health education in the Dominion, for much of its health legislation, and for a large measure of the actual services in this field. He stated that it was not so much overlapping that was in itself dangerous or undesirable as the lack of co-operation and understanding in programmes and in carrying them out.

The conference revealed that overlapping among these agencies was not nearly as widespread or serious as had been thought, and could be met by co-operative effort. In fact, it was agreed that in some instances, such as the dissemination of health knowledge, considerable benefit was to be derived from a constant reiteration of the sound facts of health teaching.

The reports on the work of the different organisations indicated that practically any need that might arise for national effort in the field of public health in Canada could now be met by the extension or adaptation of existing agencies.

The six resolutions with which the conference closed indicated the degree to which those charged with the responsibility of leadership in voluntary health effort in Canada were willing to co-operate in giving effect to their programmes. These resolutions read:—

1. That the members of this conference expressed their appreciation to the Honourable the Minister of Pensions and National Health, to the Deputy Minister, and to the staff of the Department in convening this meeting, for the courtesy and personal interest they had shown, which has made this meeting a success and inspiration to all attending it.

2. That this meeting respectfully suggest the Department of Pensions and National Health undertake a tabulated statement of all activities of the organisations here represented as submitted to this conference, and transmit the same to all organisations represented here.

3. That this meeting respectfully suggest to the Deputy Minister of Pensions and National Health that the Department make available to the several organisations represented here multigraphed copies of the proceedings of the meeting and of the reports tabled, and in the discretion of the Deputy Minister, of such further documents, including constitution, by-laws, and annual reports as each organisation may care to deposit with the Department.

4. That whereas this conference has been of distinct value to all the participating organisations, we respectfully suggest that the Deputy Minister of Pensions and National Health of Canada re-convene the conference at such time as he sees fit; and, further, that he invite the attendance of such other national agencies as he deems wise.

5. That this conference recommend that the representatives of each organisation participating in this meeting suggest to their respective boards that each organisation study the tabulation of the activities of al the organisations represented here, and that each organisation come to the next conference prepared to give the question of sympathetic co-operation and active support to all the other organisations their serious consideration.

6. That this conference recommend to all the organisations represented therein that no new type of work in the health field be undertaken by any participating organisation prior to the meeting of the next conference, or failing that, without reference to the Deputy Minister of Health for Canada.

The fact that the organisations participating in the conference represent among them a total annual expenditure of $2,000,000 on health and nursing services in Canada indicates, in some degree, how far-reaching and effective the agreement of co-operation decided upon will ultimately prove.

CANADIAN COUNCIL ON CHILD WELFARE

The tenth annual meeting of the Canadian Council on Child Welfare, held in Ottawa, November 25th and 26th, was well attended, and all sessions throughout proved thoroughly interesting and instructive.

The proceedings occupied the better part of two days, and consisted of an executive and business meeting, meetings and reports of various sections and a conference with special groups.

At the evening meeting on November 25th, the President's address and the report of the Executive Secretary were followed by a special report read by Mr. Frank Sharpe, General Secretary, Big Brothers' Association, Toronto, on "Youthful Offenders in Canadian Penitentaries." This report presented the findings of an exhaustive study over a definite period, and constituted a searching indictment of society's treatment of juvenile offenders.

This report was spoken to by Mr. H. A. Atkinson, Superintendent, Manitoba Boys' Industrial School, Portage la Prairie, who substantiated Mr. Sharpe's statements, and by Brigadier-General Hughes, who outlined the methods used in penitentiaries throughout Canada for the rehabilitation of prisoners.

The opening words of the report of the Executive Secretary, Miss Charlotte Whitton, M.A., give a clear picture of the aims of the Council: "Your Secretary has again endeavoured to carry on the work of the Council, primarily as that of a national educational agency, seeking the co-ordination of public and private child welfare services across the Dominion, and the development of a conscious effort towards the national attainment of clearly perceived standards of child welfare work that will not fall below recognised international standards in this field."

Miss Whitton's report was most comprehensive and told interestingly of the year's progress. During the year work has been carried on by the Council in every province except Nova Scotia. An intensive survey was organised in New Brunswick. Miss King, who has been engaged largely in the conduct of surveys in various parts of Canada, is now working on an analysis of Children's Protection Acts of Canada. Regional conferences have been a feature of the past year, one having been held in Calgary, another in Saint John. A course in Social Work was organised and given in Toronto at the Summer School of the Anglican Dioceses of Toronto and Niagara. The Executive Secretary expects to give three special lectures on Child Welfare to the students in the Department of Social Service at Toronto University this term, and also at the School for Social Work at McGill University. Miss Whitton spoke of two research studies which are being undertaken by members of the staff, one on case work with neglected children, the other an analysis of Children's Protection Acts.

Through the efforts of the Council certain recommendations have gone forward to the Minister of Immigration with reference to juvenile immigration. Miss Whitton reported action arising from these recommendations.

The morning of November 25th was occupied by reports of the various sections: the French-Speaking Section, the Child Hygiene Section, the Child in Employment Section, the Child Care and Protection Section, the Delinquency Section, the Educational Section, and the Section dealing with the Spiritual and Ethical Development of the Child.

Mention can be made here of only one, the Child Hygiene Section, under the convenership of Dr. Phair. "The past year has been one of unusual development for this section, owing to the inclusion in April, 1929, of arrangements whereby the Canadian Life Insurance Officers' Association generously agreed to finance the section for three years from that date. This has made possible the appointment of a full-time secretary to take charge of exhibits and publications." Many existing publications of the Council have been reprinted, and many new pamphlets, folders and posters have made a first appearance. A great number of pre-natal letters have been distributed, and post-natal letters are in course of preparation.

On the same day a complimentary luncheon was tendered W. L. Scott, Esq., K.C., Honorary Counsel to the Canadian Council on Child Welfare, at which many persons prominent in health and social work were present, and an address was given by the Honourable Dr. J. H. King, Minister of Health.

The last session of the annual meeting was devoted largely to a conference between members of the Canadian Council on Child Welfare and representatives of the American Association for Organising Social Work in reference to the proposal that the Council reorganise to become the Canadian Council on Child and Family Welfare.

Observations on the Trend of Hospital Development in Canada

By HARVEY AGNEW, M.D., Department of Hospital Service, Canadian Medical Association

It is, indeed, an honour to have the privilege of presenting a paper to this joint meeting of the Manitoba Hospitals and Nurses Associations. The executives of the three associations meeting here simultaneously are to be congratulated upon this arrangement. As our three fields of activity, nursing, hospital and medical, become more highly specialised, there is becoming increasingly manifest a tendency for our various interests to become more widely separated. This tendency is most unfortunate, for, after all, we three groups are working for the same common end—the health of the community. We may travel different roads, but our paths cross so frequently and we can be of such service to each other, that every opportunity should be grasped to further co-operation and the unification of our work.

Through the work of our department of hospital service which has been in close contact with the hospital situation from coast to coast, we have been enabled to make many interesting observations on the "Trend of Hospital Development in Canada".

Possibly the most striking observation is the tremendous increase in hospitalisation in every province. This has been especially noticeable in the decade since the war. There is a hospital building campaign now in progress which has never been equalled in the past and still practically every community reports "hospital accommodation far from adequate". Our office completed recently a list of the hospitals of Canada, a list which will be off the press within the next few weeks. We find that Canada now has 886 hospitals with over 74,000 beds. Of these hospitals, nearly 500 are public general hospitals, the remainder being sanatoria or isolation, mental, war veterans, private or other hospitals. These hospitals have an approximate valuation of 241 millions of dollars and an annual maintenance budget of over fifty millions.

These statistics are most significant. They indicate that today our hospitals have the confidence of the public as never before. Gone are the days when the public looked upon the hospital merely as a last resort—as a "place within which to die". No more do they expect to find over every hospital portal, written with skeleton fingers, that Dantean inscription, "Abandon hope, all ye who enter here".

One notes in travelling across the country that now nearly every community has its hospital. Not only is there a hospital for practically each district, but every little town in certain areas has its own small hospital. Where such towns or villages are isolated or communication is difficult, such arrangement is ideal and should be encouraged. But one doubts the necessity of some of the small hospitals in the more thickly populated districts. Where roads are good and distances are short, it is a waste of money to duplicate all this equipment and service. For instance, one good X-ray plant in a district, operated by a skilled radiologist, and the other hospitals equipped with inexpensive machines for emergency work only, is much preferable to having all of the hospitals install expensive high-powered apparatus and then find the technical or medical staff not prepared to do the therapeutic or more delicate diagnostic work.

(Read at the joint annual meeting of the Manitoba Hospitals Association and the Manitoba Association of Registered Nurses, September, 1929.)

When we consider the lamentable lack of accommodation for chronic cases or for convalescent patients, we wonder if hospital construction should not be more carefully supervised from the viewpoint of the needs of the province as a whole, rather than left to the direction of local town pride or the desires of private philanthropy. Suggestions to countries and municipalities for future construction policies could well be prepared by a special committee representing the hospital association and the provincial government.

STANDARDISATION OF PLANS AND EQUIPMENT

Many hospital executives have felt for some time that a material saving could be effected if hospital equipment could be more or less standardised. It is difficult to standardise construction because every hospital must be adapted to the needs of that particular community; but uniformity of equipment could be considered. At the present time, every steriliser must be especially assembled for a particular size of space; X-ray machines have to be squeezed into all kinds of rooms; we cannot agree upon operating room lights. Kitchen layouts, refrigerators, laundries, almost every large piece of equipment seems to require a special blueprint. Were our buildings so laid out that standard equipment could be utilised, we could reduce our overhead and still preserve sufficient field for initiative and improvement to prevent stagnation.

One notes a strong tendency for hospitals to overcome their isolation by getting together to discuss their mutual problems and difficulties. Nova Scotia and New Brunswick have formed provincial associations this year and already have been well repaid for so doing. The hospitals in Montreal have formed the Montreal Hospital Council and we can heartily commend the formation of such a council in any large city or district.

Three months ago, the first International Hospital Council was held at Atlantic City. I may add that your own Dr. Geo. Stephens was the Canadian delegate to the initial conference in Paris a year ago and contributed to the programme this summer. Forty-four countries were represented at this conference and many and varied were the excellent suggestions made by the various speakers.

We have no Canadian Hospital Association, not because we have not thought of forming one, but because of our extensive mileage. Many factors must be considered before undertaking such a scheme. We hope that in time some national organisation may be possible, but at the present time the ardent support of our provincial associations should be our chief objective.

MUNICIPALLY OWNED HOSPITALS

One notes a growing tendency to make the support of the hospital a civic responsibility. Many towns and cities now have their own civic hospital and the trend toward Union Hospitals, municipally owned, here in the West has long since passed the experimental stage.

This idea is sound, for it is only fitting that the deficit on the care of the indigent should be borne by the healthy citizens, rather than by the private patient at a time when he is down himself and least able to carry this extra load. However, we must be careful lest the impression that "we must pay in our taxes, anyway" interfere with private benefaction or other sympathetic interest in the hospital. A hospital can never become an impersonal utility like the waterworks or the fire department. It must always have a heart, a big heart, and reciprocally must hold the constant sympathy of the public. Recently our Hospital Department conducted a survey of a hospital which, formerly under a private board, is now a civic institution. In the three or four years since the change of administration, not one gift from a citizen has been received! This lack of sympathy and the interference of petty limelight-seekers are the two pitfalls which seem to be of most concern to our civic institutions.

COST OF HOSPITAL CARE

Finally, one cannot help but comment on the general public unrest over the high cost of hospital care. We hear adverse comments from all sides. A recent magazine article probably contained many true statements but the general impression cannot but weaken the public respect for hospitals. Honest constructive criticism should be welcomed—and is welcomed—but continual sniping and undermining of the public confidence is totally unwarranted by the facts. The time has come when those individuals who know the hospitals and their many handicaps should arise and scotch these canards.

The public do not know, but should know, more about the elaborate services provided by their hospitals—of the expensive X-ray plants, the costly sterilizers, the elaborate operating rooms, the laboratory, the laundry, the special diets. They do not know that an efficiently operated hospital requires as many personnel—nurses, maids, engineer, painters, etc.—as there are patients. They do not know that the average cost per patient per day throughout Canada is $3.45, and that a great proportion of our patients do not begin to pay for the cost of their care.

They should know that our administrators are seizing every opportunity to pare expenses and to combine maximum efficiency with the utmost economy.

True, much still remains to be done. Some scheme of co-operative purchasing, such as has proven so satisfactory in France, might well be tried here. Customs tariff on imported hospital supplies not made in Canada should be abolished. Group nursing has been tried with considerable satisfaction to both patient and nurse in certain hospitals, and a crystallisation of opinion on this controversial subject will be awaited with interest.

The subscriber, or "ticket" system, really a form of hospital insurance, has been so successful in various industrial, and one agricultural, areas in Nova Scotia that their new association is now considering its general adoption throughout the Province.

These efforts on the part of the hospitals to study and reduce their costs are not generally known to the public, and it is up to us as individuals—nurses, trustees, doctors, administrators—to tell them. Few hospitals really advertise themselves as they should. Hospital Day should be observed, the support of the local editor enlisted, the ladies organised and, in every way, the hospital should strive to bring about the day when the hospital will be the Health Centre of the community, actively participating, not only in the cure of disease, but in the still greater field of the future, the prevention of disease. In the words of a German delegate to the International Hospital Congress, your hospital should be "an instrument and not merely a monument".

FROM THE GOLDEN BOOKS

De Profundis

(Bliss Carman)

When at the sunset's close
Earth slowly turns to rest,
I watch the fading rose
Die in the saffron west.

The pale cool stars emerge,
And the blue robe of night
Is sown from verge to verge
With daffodils of light.

Then all the distant hills
And shadows seem aware
Of One who holds and thrills
The far away and near.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.

Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

Co-operation Between the Instructor and the Head Nurse

By KATHERINE SCOTT, Instructor, School of Nursing, Toronto General Hospital

Co-operation is a word which is assuming increasing importance, and the idea which it embodies is stressed in every modern occupation. So universal has this concept become that an Institute of Intellectual Co-operation has been established as an integral part of the work of the League of Nations. It would seem timely, then, to discuss how this same principle may be helpfully applied to the scientific training of nurses. More particularly I propose to make some few suggestions as to co-operation between the instructor and the head nurse, with a view to better teaching of student nurses.

If the instructor and the head nurse are to co-operate they must work together, one in the class room, the other on the ward, to promote a common object: that object is to create a more intelligent understanding of her work in the mind of the student nurse, with the ultimate result of better care of the patients.

The most obvious method of co-operation is, of course, the meeting of instructor and head nurses to demonstrate and discuss nursing procedures. I would suggest that this be done at least once in six months, unless some unusual circumstances necessitated a more frequent meeting. It is hardly necessary to mention that, on the one hand, class-room teaching should be suited to ward requirements, and, on the other hand, that ward equipment should parallel class-room demonstration.

The instructor may be somewhat insistent upon a certain method of procedure which is not feasible on the ward. Here a frank discussion will yield the result of a standardised procedure rather than two separate and distinct types, one for ward and one for class-room. Too often this latter situation develops in the mind of the pupil nurse the unfortunate attitude that class-room teaching is impractical for ward purposes.

Very often a nursing procedure of long standing is suddenly altered by the express wish of the chief of staff. The instructor, however, is not in direct contact with the doctors and can only learn of the change from the head nurse. A very real co-operation may be developed in this regard. On the other hand, the instructor might aid the head nurse by keeping her informed of the procedures being currently taught. The head nurses may then know better what may be expected of their students and may arrive at a truer evaluation of their capabilities.

Perhaps one of the most important, and at the same time, most difficult courses of study in the whole

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(Given at a Round Table on Nursing Education at a meeting of District 5, Registered Nurses Association of Ontario, November 30, 1929.)

hospital training is that of materia medica, and here the head nurse may be of incalculable help to the instructor. In the class-room the study of drugs, their action and dosage, is almost entirely confined to memory work. On the ward, the giving of medicine is too often merely a matter of routine. But if ward and class-room can be brought in close touch, this branch of nursing care may become one of the most fascinating of a nurse's duties. In this connection, I should like to suggest a weekly conference between the instructor and the head nurses, at which the former might outline the medicine which she is at the moment discussing. Those head nurses on whose wards such drugs are in use might then take a few moments, perhaps at morning report, to draw their students' attention to these medications. It would be a simple matter at such times to explain the usual dosage, purpose and results, together with symptoms of over-dosage. The pupil nurse realises that the hitherto unrelated class-room teaching is her preparation for the vital work on the wards, and instinctively she begins to note the effect of drugs on her patients. Discrimination and observation are thus developed.

In some hospitals another effort towards co-operation between teaching and practice has been the establishment of libraries on the wards. These ward libraries include the standard text books on Nursing, Anatomy, Dietetics and Materia Medica, Case Studies, together with Medical Dictionaries. In addition, each ward library contains certain text books dealing with the types of conditions which are peculiar to that ward. Definite assignments of reading, mapped out by the instructor, may be read while on duty on the wards. The head nurse must be in sympathy with such an arrangement, make possible the time for reading, and suggest further references.

That such achievement of co-operation between principle and practice is not idealistic but practical may be demonstrated. Certain departments of the hospital lend themselves to a natural development of this co-operation. In the Operating Room, the Obstetrical Department and the Out-Patients' Department a great deal of the teaching is done in connection with the practical course.

Further developments along this line might be worked out in other departments which would add greatly to the interest of the student.

During all this discussion it must be remembered that co-operation is very intangible, depending largely upon the personalities of the individual instructor and head nurse. A sympathetic understanding of each other's problems and difficulties is indispensible. An interested instructor will visit the wards and acquaint herself with the patients and conditions there in order that she may keep in close touch with her students. At the same time she will acquire first-hand knowledge of the many duties and various difficulties which confront the head nurse. Through the medium of the weekly conferences, previously suggested, the head nurse will meet the instructor and realise afresh her responsibility not only as a ward administrator, but also as the logical teacher of the students in her charge.

The head nurse must have a tolerant understanding of what has to be taught to students and she must realise what a large part she plays in the teaching. On the other hand, the instructor must be able to put herself in the place of the head nurse, who has many obligations other than towards student nurses.

Where head nurses and instructor meet on such mutual grounds of sympathy and co-operation it is inevitable that progress will be made in the education of nurses and better care of patients will result.

Nursing Problems

By HELEN R. WAKELING, Superintendent, Estevan Hospital, Estevan, Sask.

Since the nurses represented at a hospital convention are usually superintendents of hospitals, or their assistants, the problems under discussion will naturally be those concerning them. I am not in a position to speak of the difficulties arising in the larger institutions, so will confine these observations to the problems arising in the smaller hospitals, particularly as there are more of this type than the larger in this province. These problems are usually connected with the relationship of the nurse in her dealings with the various phases of hospital life, namely:

The Administrative Body.
The Training School.
The Doctors in attendance at the Hospital.
The Patient.
The Public.

The Administrative Body:

Here, as in other departments, any trouble which arises between the nursing staff and the board of directors is usually due to some misunderstanding between them. For this reason the members should be representatives from various walks of life, so that every problem likely to arise in the hospital world may be thoroughly understood. As a rule, it is easy to find men of business acumen to handle the financial affairs of the hospital, but there should also be at least one physician and one surgeon, and if possible one nurse (married or not connected with the hospital in any way) to form a link between the medical and nursing aspects of the hospital and the administrative body. Since the board is really the final court of appeal in every difficulty, no undue emphasis should be placed on any one department. Nursing problems, however, should receive all justice and consideration, since the good name, or otherwise, of the hospital depends largely upon its nursing personnel. The support of all the members of the board means a great deal to the nurse in either a large or small hospital and determines to a great extent her position in many other phases of hospital work. Personally, I am not in a position to discuss the problems arising between nurses and hospital boards, as the Estevan Hospital is a private institution. There is, however, a marked absence of friction there, and we ascribe this to the mutual understanding between the doctors, who also take the place of the governing body, and the superintendent.

Now, while it is a fairly simple thing to secure co-operation between two men, it is often an entirely different matter for twelve men to agree on every subject, and the superintendent is often the one to suffer from the results of such disagreement. If all arrangements could be made by one member of the board so that the doctors and the superintendent would be responsible to one individual only, it might eliminate the difficulty of trying to satisfy each member in his own particular department. In this respect we find that the employment of a full-time secretary, who has entire charge of the finances and of the general administration, helps considerably both in the collection and payment of accounts, and also leaves the superintendent free to devote her time to the work of the training school and to the supervision of the care and treatment of the patients. The myriad departments in the small hospital requiring the attention of the superintendent make it impossible for her to personally see every patient who leaves the institution in order to secure definite arrangements regarding the payment of accounts.

(A paper given at the annual meeting of the Saskatchewan Hospital Association, September, 1929.)

Where a secretary is always on hand to manage this part of the work, satisfaction is increased for the hospital, for the superintendent, and for the patient himself.

The Training School:

Of the problems relating to training schools, the selection of suitable probationers is by no means the least. The success of the training school depends largely upon the personal interview with the applicant and the acceptance of students not living in the city, or in the immediate vicinity of the hospital. The ignoring of this factor frequently gives rise to disturbance between the families of the pupil nurses and is liable to upset the morale of the training school. The foundation of the right type of nurse is laid during the first few weeks. It is during this period that the young woman is becoming adapted to her surroundings and receiving her impressions. The early days in a hospital do more to make or mar the student nurse than all the rest of her training. If during this period extra effort is put forth to instill into the particularly receptive mind the ideals of nursing, the practical side can be emphasized later, and there will not be much cause for worry over problems of discipline, loyalty, etc. One difficulty which frequently confronts the nursing faculty in the training school is the health of the student nurse. The absence of one or two nurses in the smaller hospitals can make a great deal of extra work for all the rest, and as this usually occurs during an exceptionally busy period, the added strain places more and yet more upon the sick list. The first year of training seems to be more beneficial than otherwise, but often during the second year the student lags in her work, loses weight and sometimes even develops a serious ailment. Change of work, particularly if of a lighter description, helps to adjust this, and we find here that the affiliations with other hospitals contribute largely to this effect. We arrange the affiliations of our students, as far as possible, to take place during their intermediate year, and, contrary to the fear still prevalent among many people of contact with tuberculosis patients, we try to send our girls to the sanatorium whenever they show signs of being run down.

The problem of keeping the training school up to standard might be solved for the superintendents by frequent and helpful inspection. Nurses in general, however, would, I think, insist on Canadian rather than American standardisation of their profession. If the responsibility of the superintendent in keeping the training school up to the mark could be shared by some one who had the opportunity of viewing the various hospitals in perspective, of noting the excellencies and the flaws, it would provide the necessary stimulus which at times seems sadly lacking.

The Doctors:

Hospitals are essentially places for the carrying out of doctors' orders, so that the nurse is responsible not only to the board for the care of the patient, but also to the doctor for the accurate fulfillment of every order. This is often a cause of disagreement and strife in hospitals, and the nurse frequently receives more than her share of the blame and sometimes is made to bear the brunt of the doctors' mistakes. However, many doctors think this is their privilege and fail to understand why orders are not carried out promptly when they are mumbled in an absent-minded way, or given in snatches during the recounting of a story of some other doctor. Orders are rarely written except under pressure, in spite of the fact that no verbal order may be accepted. To the charge nurse in a hospital the doctors present one of the chief problems, particularly as in some hospitals great care is necessary in remembering each one's peculiarities (doctors do have peculiarities), and in endeavouring to render equal service to all. Case records form a bugbear in many a nurse's life, for few in charge of hospitals have not discussed the problem of how to make doctors write up their cases. Problems concerning the patients should also be those of the doctor attending the case, and any misunderstanding in the care and treatment of that patient or error in the order should be settled by him. This, if in a training school, is better done in the presence or with the assistance of the charge nurse, not with the idea of reporting and making trouble if a student is to blame, but for the purpose of helping in the work of the training school and insuring the comfort of the patient. Constructive criticism and thoughtful consideration on the part of the doctor can result in nothing but help and encouragement to the nurse with whom he works. While open disapproval is rarely shown on the wards, yet often much can be inferred from the doctor's manner, and this is certainly not fair to the nurse who needs all the confidence of the patients in her charge if she is to secure the best results. Strange as it may seem, two professions which are so alike are often at variance with one another. Each is entirely separate, yet each is wholly dependent upon the other. Most of the trouble arises from failure to understand the demand made by each.

The Patient:

The patient naturally presents the greatest problem, particularly when, as often happens, the nursing care is given as the reason for a delayed recovery. One problem often discussed is how to secure the maximum service for the minimum cost to the patient. Various suggestions are made, such as group nursing. It has also been questioned whether in the smaller hospitals better service might be secured for the patient with graduate nurses in attendance than with students in training. Most people connected with small hospitals are of the opinion that there is no disadvantage to the patient when cared for by student nurses if careful and capable supervision is also provided. On the contrary, it is often found that public ward patients receive better attention in the smaller institutions than in the larger hospitals. There is greater opportunity for the personal touch and more attention can usually be paid to the details of personal peculiarities and preferences. Because the small hospitals depend so much upon the good-will of every patient, particular care must be taken to see that there is no reasonable cause for dissatisfaction. The problem of the patient who appears satisfied when in the hospital yet grumbles to his friends after discharge is one few hospitals have not had to face. The difficulty here lies in the fact that there often is a reason, no matter how trivial, for the imagined poor treatment. In discussing hospital treatment with ex-patients from various hospitals we find that the grievance is usually not so much against the actual nursing care but is more often based upon the quality, preparation and serving of meals. This undoubtedly is an avoidable matter and is a factor to be considered when retrenchments in hospital expenditures are discussed.

The Public:

Misunderstandings and difficulties sometimes arise in the nursing world through failure on the part of the public to understand the reason for many of the rules and regulations of hospitals and nurses in their management of the sick. Much of this could be averted if kindly explanation were made by the nurses, backed up by the doctors and the hospital board. In the matter of visitors, for instance, the best efforts of the nurses are sometimes frustrated by the continual presence of well-meaning and over-anxious friends and relatives. If it is possible at all to make arrangements whereby the nearest of kin may remain in the hospital, if not in the ward, or at least receive the courtesy of kind consideration, they will usually be found to be more tractable than at first appears. In these, as in other things, the co-operation of the attending doctor and the hospital board is necessary, and if secured does much to solve the problems which so often arise, particularly in the smaller places where people usually expect to receive more privileges and are in fact often allowed more latitude.

This is an era wherein more or less publicity is given to every subject, including the medical profession, and evidence of this may be seen in the various articles which are placed in the daily papers by men like Dr. Copeland and others. These articles are written with the approval of the medical profession, and help to impart a certain amount of correct knowledge to the public. A similar method might be adopted by those associated with hospital and nursing work, giving the reasons for many things often only faintly understood, and justifying many seemingly inexplicable actions. Considerable notoriety is gained when anything goes wrong in the hospital world, but very little of an instructive nature is written. Articles of this description would be widely read and might help to simplify many of the problems besetting nursing and hospital administration.

In conclusion, friction among the administrative bodies, lack of cooperation from the public, and insufficient consideration by the medical profession are some of the chief difficulties in the field of nursing. The appointment of one particularly responsible member of the board, who may also perform the work of a full-time secretary, is suggested as a solution for the first, education of the public chiefly through the medium of the daily paper as the second, and the recognition by the medical profession of the fact that nursing is a profession of equal importance to that of medicine is given as the third.

Nursing problems must of necessity be also those of the hospital, and of the public and the medical profession, since nursing is intimately connected with all three. None is sufficient unto itself, or subsidiary to the other, but all are dependent upon and are allies to each other. Only by harmonious co-operation and complete understanding of all departments can the greatest results be obtained.

An Educational Problem of the Smaller School

By C. E. ARMOUR, Superintendent of Nurses, Jeffery Hale's Hospital, Quebec

A well used library is a very necessary adjunct in the mental growth and development of the student in any school, and schools of nursing are called upon to secure this aid.

In the larger schools a full-time librarian may be in charge and the students benefitted by the supervision and valuable help she will be able to give, but in the smaller school this phase of study becomes a problem.

While some work has been done regarding compiling lists of recommended text books, and reviews of nursing works published in our National Nursing Journal, I am under the impression that the use of the school library has not yet been made the subject of a special study.

Our problem seems to be: how to acquire and control a library suited to the needs of our student body.

If a student is given reference reading, a case study, or wishes to read along a line of study suggested by a doctor's lecture, we should be able to give all possible aid in conservation of time and the supplying of adequate and profitable material.

As the initial outlay for such a library is considerable, material in nursing works changes rapidly as medical science develops, and there is a constant outlay for missing books, this need might be met in a more satisfactory manner, as well as more economically, by the inauguration of either provincial or national aid. This could take the form of a Service Bureau, where a student or teacher could apply for help when wishing to prepare herself along any particular line of study. Books, pamphlets, or magazines might be indexed and cross-indexed, so that they would be readily available for reference when requests were filed for information, in a more thorough way than is possible unless a trained person is in charge. Whether this Bureau sent out material for a given time, or merely gave advice with references, would be a matter for discussion.

This project could be financed by charging a membership fee to each school, by alumnae aid, or by making it a memorial to some of our pioneer educators.

A library to be a real help to the student must contain the proper material, have a person in charge who knows what that material is and where it can be found, and one who is interested in education. As already stated, a large school can employ the services of a full-time librarian, but in the small school this phase of education become a problem. A recent writer has said, "The text-book mind is one of the perils of our age," and if we are to avoid this evil we must provide our students with the facilities for investigation and observation and, by whatever means possible, guide them to a critical evaluation of available material. How to select, how to obtain the current literature pertaining to nursing, is the problem confronting us.

Editor's Note: We are indebted to Miss E. Frances Upton for obtaining the above contribution. Miss Upton writes that as a member of the School for Graduate Nurses Alumnae, McGill University, she hopes to be able for some time to supply monthly contributions from members of the Alumnae who are now engaged in the administration of schools of nursing.

No doubt Miss Armour's problem is common to many schools. However, as one or more schools may have solved this question, the Editor will appreciate receiving material for publication on the subject of libraries, their administration, etc.

The Adelaide Nutting-Lavina Dock Prize

The response to the offer of this prize has been immediate and shows that much interest has been aroused. Everyone will be glad to know that the contest is open to nurses from all countries, since this will make the competition keener and the level of achievement will undoubtedly be higher than in a purely national contest. (See *The Canadian Nurse,* December, 1929—Ed.)

The committee hopes that many of the essays entered, whether prize winners or not, may be worthy of publication and may contribute material of permanent value for students of nursing history in all countries. In this connection it may not be out of place to suggest that the subjects chosen should be of more than local interest and that the contestants should aim at a standard of historical writing which will do honour to the two pioneer writers for whom the prize is named. While beginners are not excluded from the contest, it may save some disappointments later if it is frankly stated now that a good background of historical knowledge and some training in historical writing are presupposed in such a contest.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

Mental Hygiene and Public Health

By Dr. S. R. LAYCOCK, Department of Education, University of Saskatchewan, Saskatoon

II.

In my previous address I spoke to you concerning the general programme of Mental Hygiene, and there I pointed out that, from the viewpoint of the psychologist, the term mental disorder differed in two respects from popular usage. First of all the psychologist includes under the term, mental disorders, all those mental traits that hinder the individual in adjusting himself to his fellows, to life as a whole, and to himself. I pointed out then that temper tantrums, feelings of superiority, emotional upsets, secretiveness, suspiciousness, sullenness, etc., were classed as mental disorders, and that, on that basis, few of us could claim to be free. That wherever a child or an adult suffered from any of the above or of a host of others, such as self-pity, boastfulness, bullying, oversensitiveness, stubbornness, and excessive day-dreaming, he was in need of mental adjustment or treatment in a somewhat similar way as those suffering from more grave forms of mental disorder found in our mental hospitals. Also I wish to remind you of the second point: that there is no sharp line of demarcation, psychologically, between the sane and the insane.

I also tried to suggest the problems of adjustment which faced the child in pre-school years and the tremendous range of new problems which opened up with the years of school life. These problems of adjustment continue into adult life, and I wish you to think with me for a little while of the way in which people make adjustments when face to face with reality.

One of the most interesting ways by which children and adults make adjustments when faced with the problems of life is by regression to an infantile stage of behaviour. This is illustrated by a case cited by McDougall of a young Australian soldier, who had been sent to a hospital for complete loss of speech, following shell-shock. He was recovering fairly well under treatment when there occurred a series of severe air raids which threw the hospital into confusion and made necessary the hurried removal of the patients. As a result of the second fright, the young soldier underwent a startling transformation —he became a child. Literally so. He lost completely the power to speak. Given a pencil he was utterly at a loss what to do with it. He seemed to have forgotten the use of the ordinary things about him, which he examined with a kind of mingled curiosity and timidity. He walked jerkily, his feet planted wide apart, and if he was not supported he would quickly slip down and crawl about as a child does. He could not even feed himself, and when fed by his nurse, insisted that she taste each spoonful first. He played in a childish manner with various objects, making toys of them, and he quickly adopted and became very devoted to a small doll which was kept as a mascot in the ward. Here was a complete case of regression to the infantile. The young soldier was not feigning. He *was* a child.

At first blush, such a case seems to have no likeness to anything that happens in everyday life, but if we examine the reactions of children and adults, we can find abundant evidence that the above illustration is only an exaggeration of what commonly occurs.

Overstreet tells of a woman who suffers from a form of infantilism. She never approaches a new task save with the impulse to postpone it. If it is to

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(Read at the annual meeting, Saskatchewan Registered Nurses Association, April, 1929.)

write a letter, she will do something else first. If it is to ring someone on the phone and arrange an engagement, she will decide to do it later. If it is to make a decision, she will put it off as long as possible. Somewhere in that woman's childhood there was a failure in education. An examination of her life reveals an over-solicitous mother. "Helen, you must not go out without your rubbers." "Helen, you had better be home by five o'clock." "Helen, I think you had better not wear that colour, it is a little too violent." At forty-five, Helen still wants things decided for her. Being unmarried, she has no husband to take the responsibility, and she shirks. Every new task holds terrors. She pushes it off; procrastinates; hopes that the new thing will not have to be faced. Normally, this woman is grown-up; but when there is a situation to be faced, she suddenly slips back into the condition of childish timidity and irresolution.

I wonder if you cannot think of examples from your nursing experience that very nearly parallel the cases cited. Have you met patients who wouldn't face the issue of going to the hospital, who wouldn't face the issue of calling a doctor, who wouldn't face the issue of having an operation that should be performed, who wouldn't take their medicine or tried to put it off, who tried to put off treatment they were supposed to take? I wonder if it occurs so often that you have almost come to accept it as inevitable. Instead of standing up to reality and facing facts squarely, deciding what is best and wisest to be done, and then going through with it, these people slip back to a childish state. They regress to the infantile. In their home and school and childhood life, they have not been trained to face the realities of life. Something has been lacking in their mental fibre. And as proof of the fact that they have regressed to the infantile, the nurse treats them like a child, soothes and persuades them, just as a child is often treated, or else is firm in the same way one may be firm with a child.

Another form of regression is not at all unusual. Overstreet tells of a man who, when his coffee is cold or his sausage too tough, throws down his knife and fork and stalks out of the house in a rage and goes to a neighbouring restaurant. Tantrums. What are they? In the child they are a sign of the fury of impotence. The child wants something. The thing is refused. The child cannot bear to accept the refusal. Instead of facing the situation squarely, trying to get what he wants by longer ways that are calm and considering, the child flies into a rage and tries to secure his ends, often does secure them, by making a nuisance of himself. Adults on occasion make nuisances of themselves. Those who use the temper tantrum slip back to the childhood technique of getting what they want. They are not prepared to meet adult problems in a calm and reasoning way by facing reality with adult technique.

The pout is another form of childish adjustment that is used by school children and adults as a means of evading facing the issue clearly. Of like nature also is sulkiness, sullenness, and the whine. These are all forms of behaviour built up in childhood by means of which the child gets what he wants. They should never have been built up in the child and they should never have been carried over into adult life. Let us think of the whine for a moment. It is never a way of facing the situation squarely. It is not an attempt to find out the facts, to estimate the values. It is a flight into "low-geared rage". Unsuccessful men frequently take to whining. Let us take the case of a fairly brilliant man. For one reason or another, things have not gone well with him in business. He has been denied opportunities he doubtless should have had. He has been embittered, and takes it out in whining. He whines to his friends and to his family and has thereby become a long-drawn-out domestic pest. His little boy now whines and his wife shows the inevitable marks of the marital misfortune. What he needed was to face the facts and ask how much of the lack of opportunity was due to personality traits in himself. Whining is a way of escape. It is also a regression to the infantile.

I do not know how often temper tantrums, pouts, whines, etc., occur in patients. But I do recall on one occasion in hospital the case of a woman who occupied the ward opposite to mine and who was able to sit up in bed. She threw her tray on the floor because the nurse was not there to remove it the instant she had finished. She was querulous and annoyed each time her light was not answered forthwith. She was a grown-up spoiled baby, who used childish adjustments for adult situations.

Still another form of regression found in the normal life of the child is that of boastfulness and bullying, which is boasting with one's fists. The child is in urgent need to find a place in the sun for his diminutive personality. Everything around him is bigger than he. His parents and his teachers dominate him with the bigness of their bodies, as well as the bigness of their authority. The furniture was made for people bigger than he and the books and papers around him are accessible to the bigger people, while they baffle him with their strange incomprehensibility. On all sides he is made to feel that he is an infant and that he is still not grown-up. As a result we often find that one of the commonest characteristics of child life is a proneness to boasting. It is pretty well agreed among psychologists that a child's boastfulness is usually an effort to compensate for his feeling of inferiority. He is trying to prove to the world that he is a creature worth noticing. His boasting, like his sense of values, is fairly crude. "I've got a bigger boat than you." "My father has more money than yours." "I can lick all you fellows easy." And that boasting and bullying often carries over to adult life. It shows itself in the way we lay claim to the smashing superiority of our country, our city, our race, our university or our family. And the bully exists in adult life. Often the man who occupies an inferior position in a factory or office "takes it out" on the family at home. Boasting, swaggering, bullying, belong to an infantile stage of life. The wise teacher will see to it that the child meets the older age-levels with more mature adjustments in order that the happiness and welfare of the individual and others may be insured.

Another method of withdrawing from reality is by day-dreaming. To face the stern facts of reality and our own limitations is painful, and we withdraw into the realm of imagination. Here we can arrange details to suit ourselves. If reality deals a blow at our estimate of our own importance, we can avoid the issue by thinking of ourselves as conquering heroes, and in imagination we can be the greatest orators, musicians, doctors, lawyers, and philanthropists in the world. Some day-dreaming of the conquering hero type may do little harm, but any large amount of it is dangerous for either child or adult. There is the danger of substituting phantasy for action and remember it is only a difference of degree between the day-dreaming child and the patient in the mental hospital, whose phantasy has become so divorced from reality that he thinks himself God or the Prince of Wales or Colonel Lindbergh.

Probably a more subtle form of day-dreaming or introversion is the suffering hero type. In this the individual withdraws from a cruel world and takes great satisfaction in self-pity. He is of finer clay than the others and is not appreciated. People don't understand him; they are down on him; they are out to get him. Instead of placing the blame on his own failure or limitations, he regards himself as a martyr. You need only look about you to see that self-pity is one of the major curses of mankind. What hosts of people make martyrs of themselves when there is no necessity! How we love to talk of our illnesses and operations, and how many people really do "enjoy poor health". And then there are the people who have been mean to us; how we love to talk of them! The amount of human unhappiness caused by a retirement from reality to self-pity is incalculable, and these maladjustments have their beginnings in child life. Every bump, every fall, every disappointment is magnified, whether it is serious or not, until the habit of self-pity is so built in that it is a part of adult character. The child can be taught to ignore minor difficulties and sympathy can be reserved for those more real problems of childhood that we now often miss. And in the case of self-pity as of our other mental maladjustments, we find the extreme of the tendency in the patients in mental hospitals who have delusions of persecution. They feel that people are plotting their downfall, trying to poison them or in some other way do them injury. Indeed I suspect that nurses, especially those in private nursing, have to listen to many tales of woe in which the patient enjoys the exquisite luxury of martyrdom and self-pity.

Mental adjustment may also take the form known as rationalisation or wish-thinking. Rationalisation is a form of reasoning in which our emotions and personal desires act as selective factors so as to guarantee an agreeable conclusion. As a process it means the complete blindness to all the evidence except that favourable to our side of the case. Practically, it means that every day of our lives we give reasons for our actions—reasons to ourselves and others which are not the real reasons. We are either unaware of the real reason, or we are too ashamed of it to look reality in the face and admit the facts. Gates gives the following example. A middle-aged man buys an automobile and shortly after his older and more sagacious uncle, paying a visit, says: "It seems to me you need furniture, a new fence, a fund for sending your children to school, a nest-egg for a rainy day, more than you need this machine." But the buyer has a ready defence: "Well, my wife hasn't been any too well and I thought that a week-end trip now and then would do her a lot of good. Then the children caught so many colds last winter because they got wet going to school." And so on with other "reasons". Now what were the real motives? Perhaps the fact that other neighbours had cars which were veritable badges of greater business success. Perhaps driving a big machine appealed to his urge of self-assertion. One more example will make the point clear. If we are tempted to take an afternoon off for golf when we really should work, we camouflage the issue by saying, "I have been working hard and need a rest; I must be careful of my health; a little recreation will double my capacity tomorrow."

One form of rationalisation is the universal tendency to project the cause of our failures or misdeeds on some other person or thing. If, in coming in in the dark, we knock our shins against a chair (due to our own forgetfulness) we blame the chair and may even chastise it. Missing a stroke in tennis, we look inquiringly at the ball or the racquet. The clumsy workman accuses his tools. If we fail in an examination, the questions were unfair. If we sin, we were irresistibly tempted. If a man amounts to nothing, it is because he didn't have a chance. There was once a man who, when his house was burned through his own carelessness, said: "It was the Lord's will". By projection we escape the annoyance consequent on the admission of our failures and deficiencies.

This tendency shows itself in school life in excuses of all kinds. If work is not done, it is the parents' fault, or the teacher did not make the assignment clear; if the pupil fails, it is the teacher's fault. It is seen in being a poor loser in games, in blaming the referee or the unfairness of our children. It is seen in evading punishment and in putting the blame on others. And the teacher in turn sometimes blames her own inadequacy on the stupidity of her pupils, or the perverseness of human nature. When a child continually shows the symptoms of self-excusing, when he fails to see himself as the one at fault and is always imputing the fault to someone else, his case needs attention, for if such symptoms are permitted to grow they may develop into delusions of self-righteousness and persecution, which may make him an intolerable personality. The trouble with the children just described is that they are not solving their real life problem, which is to learn how to live together with their fellows. Unless they learn it in childhood, they may never do so.

Perhaps before leaving the subject of projection, a more extreme example might be given. This case is quoted from Sands and Blanchard "Abnormal Behaviour". A certain married woman of 55 was taken to a mental hospital. She had been annoying many people with letters of complaint about her husband, her children, and her doctor. When her history was finally unravelled, it ran something like this. As a girl she had had several homosexual episodes. Once she approached a friend in this way and was sternly rebuked. From then on she began to make disparaging remarks about her friend, stating that the latter was jealous of her and was an immoral woman. Later, when she was married, she had several periods of great excitement in which she publicly accused her friend of trying to influence her husband and her children against her. At the age of 47 she became so unmanageable that she was committed to an asylum. After a time she was released to the custody of one of her daughters; but she caused so much annoyance by her letters of accusation to prominent people that she was recommitted to the mental hospital. Let us note the psychological processes at work. Early in life this particular woman had had emotions which she was not free to express. There was therefore guilt-feeling in her; fear-feeling; the feeling of not being like others; the feeling of longing for something not permitted. Once when the strong emotion did actually break through, she was openly rebuked and shamed. Now we are all, first and foremost, creatures of self-defence. So at the crucial moment of shaming, there was a leap to self-defense. She could not bear being branded as the guilty party even to herself. So the curious trick was performed which we find so often taking place in our emotional life; she projected her guilt into the other person. The rest of the story is clear. Once this projecting of her guilt into someone else began, it became the solving process of her life. It saved her own self-respect. Her life thereafter was chiefly a search for available scapegoats, with herself always the innocent and persecuted party.

Hosts of other examples might be given but we shall content ourselves with two or three more commonplace ones. The art of projecting our own faults into others takes an ugly form in snobbery. The newly rich join exclusive clubs and refer to others as "vulgar," "uncultured," etc. By loudly proclaiming their own distaste of these qualities, they can to an extent gain credence for their own refinement.

Again, if persons are overfearful, they tend to project their fears outside themselves. The intellectually timid person finds a Bolshevist at every turn and corner just as the boy who, shivering past a cemetery, turns headstones into ghosts.

So also individuals project their hatreds. If one can project one's hatred into the person one hates so that one sees the latter as himself a hater, his own hate is thereby justified. One can now give it full and glorious swing.

A more pathetic form of the projecting tendency is seen in shyness. The shy person comes into the room and is at once certain that everyone is looking at him. He sees a girl glance at him, then turn and say something to her partner. He notes an answering ironic smile and instantly he is sure that he was himself the subject of the remark. The shy person makes himself perfectly miserable by the simple process of believing that his own sense of inadequacy exists in the minds of his observers. If the shy person could become convinced that practically nothing of what he imagines ever really takes place; if he could get the idea that no one is even so much as thinking about him, his shyness would vanish. He is, in short, the victim of his own projective imagination.

(To be continued)

The Northern Ontario Victorian Order Regional Conference

By **ETHEL CRYDERMAN, Central Supervisor**

The second Victorian Order Regional Conference was held in Cobalt, October 25th and 26th, 1929. This conference was organised at the request of the Cobalt Association for the six adjacent Victorian Order Districts, the objective being not only to give Victorian Order Board members and nurses an opportunity to discuss their responsibilities, their interests and their problems, but to bring together representatives from voluntary and official health agencies, service clubs and organisations, as well as interested individuals.

The interest of the citizens of Cobalt was aroused, hospitality was extended to the delegates, and the entertainment included a trip to the Nipissing Mine. The conference was officially opened with a banquet, and in addition to the Chief Superintendent, and the Central Supervisor, Dr. Grant Fleming, a member of the Executive Council, the Board members and nurses from adjoining districts, the Provincial Department of Health, the Ontario Medical Association, the Ontario Red Cross, the Metropolitan Life Insurance Company and the Social Service Council of Ontario were represented. In addition to these there were present medical officers of health, provincial and municipal, public health nurses, charge nurses from outpost hospitals, as well as many other representatives from various parts of Northern Ontario.

Following the banquet there was a public meeting and Dr. Fleming spoke on "The Need for the Voluntary Organisation." Following this address there was a general discussion and a great many appeared keen to participate. It was rather significant that in this small northern town there were gathered together so many people with such varying health interests and that all were anxious to emphasize the value of the volunteer group in public health work.

The following morning there was a round table conference for Victorian Order Board members and nurses, at which Miss Smellie presided. Questions of particular interest to a visiting nurse association had been carefully selected and were discussed freely. The responsibility of a board to the community, the type of organisation which functions most successfully, various forms of publicity and many other questions of vital interest were considered. Practically everyone present contributed, and later many people spoke of the new ideas and fresh interests which had been stimulated through this frank and open discussion. At the close of this round table the following resolution was passed unanimously: "That a second Victorian Order Regional Conference be held in Northern Ontario in two years' time."

The Cobalt Regional Conference was a great success. Due to this opportunity to get together, become acquainted, tell about one another's interests and discuss amicably one another's problems, many went away not only with a better understanding of their own association and with a keener, finer appreciation for other health agencies, but with a realisation that it is only in assuming a broad health outlook that any organisation can attain its fullest possible development.

MISS MAUDE HALL

Miss Maude Hall, recently appointed Assistant Superintendent of the Victorian Order of Nurses for Canada, is a graduate of the Johns Hopkins School of Nursing and of the course in Public Health Nursing at the University of Toronto.

Miss Hall's wide and varied experience includes private duty nursing, overseas service, employment with the Massachusetts-Halifax Health Commission and the Department of Health, Toronto.

Miss Hall served for some time in the capacity of Supervisor in the Washington, D.C., Visiting Nursing Association, going later to Holyoke, Massachusetts, as Director of the Visiting Nursing Association of that city, and more recently has been attached to the Public Health Clinic at Dalhousie University, Halifax.

BOOK REVIEWS

Urological Nursing, by David M. Davis, M.D., Assistant Professor of Urological Surgery, University of Rochester. Illustrated. Published by W. B. Saunders Company, London and Philadelphia. Canadian Agents, McAinsh & Co., Limited, Toronto. Price $2.25.

This book contains timely information required for instruction in the anatomy, physiology and pathology of the urogenital tract, as well as that regarding instruments and apparatus and the special nursing technique in urology.

News Notes

ALBERTA

The annual convention of the Alberta Registered Nurses' Association was held conjointly with the Alberta Hospitals' Association and the Alberta Association of Public Health Workers, on November 18th and 19th, in the Memorial Hall, Edmonton. By Sunday night the majority of the attending nurses from the widely settled points of Alberta had registered in the City. The attendance on both days was fairly satisfactory but it did not quite realise expectations.

The Monday morning session was given over entirely to the business matters of the Association, while in the afternoon the time was taken up with meetings of the various sections.

Miss M. F. Gray, Assistant Professor of Nursing, University of British Columbia, the principal speaker for the Nurses' Association, gave food for thought in her helpful suggestions and criticisms in the many and varied problems of Nursing Education, the aims of which are all towards the building up of a group of better qualified nurses and more intelligent and useful citizens.

Intelligence Testing of the student nurse as an aid in determining what abilities and capabilities the nurse herself must have to be successful as a student in a nursing school was forcefully dealt with by Dr. M. Lazerte, Associate Professor Psychology and Education, University of Alberta. Tests are needed that will measure nursing abilities, and that will accurately point out the kinds and degrees of skill, of mental ability, of social intelligence. These and many other qualities are necessary for the nurse who is to be a success in her profession.

Dr. Geraldine Oakley, Medical Inspector of Schools, Calgary, ably led the Round Table discussion at the meeting of the Public Health Section on School Nursing. Many and varied were the problems brought up for consideration, all centering mainly around Child Welfare and the nurse as a teacher of Health. Miss Blanche Emerson, City Clinic, and Miss Kate Connor, Normal School, Edmonton, gave most interesting contributions.

The Tuesday session was held conjointly with the A.H.A. and A.A.P.H.W., at which several papers of outstanding interest centred around the Hospital, its needs and uses, as well as the protection of the student from the standpoint of "Health" and methods for its improvement.

Calgary: Addressing a meeting of the Calgary Association of Graduate Nurses on November 17th, in the Public Library, Mr. S. K. Jaffray, of the Mental Hygiene Division, Provincial Department of Health, gave an informing lecture on "Mental Hygiene". A large attendance of nurses listened to the interesting address.

Mrs. M. Blunden was the C.A.G.N. delegate to the recent A.A.R.N. convention held at Edmonton.

Miss Ann McKee, Treasurer, C.A.G.N., is recovering after a recent operation for appendicitis.

BRITISH COLUMBIA

Result of Examination for Certificate of Registered Nurse

The following is the list in order of merit of nurses who passed the recent examination for title and certificate of Registered Nurse, held throughout British Columbia.

1st Class—80% and over—Misses H. R. Burton, Royal Jubilee Hospital; M. E. Henderson, Vancouver General Hospital; M. E. Carruthers, Royal Jubilee Hospital; D. G. Comley, Ladysmith General Hospital; W. F. G. Ede, Royal Jubilee Hospital; A. Clarkson, Royal Jubilee Hospital.

2nd Class—65% to 80%—Misses Helen Minto Campbell, M. L. Tennant, S. D. Andrew, E. Anderton, K. L. Hartney, R. E. Stickle, M. E. MacKay (L. Henry, V. Danders—equal), F. V. Bell (H. A. E. Hanson, M. E. Hill—equal), M. C. Minchen, R. A. Wrinch, A. L. Brock (P. M. Hamilton, F. C. MacDonald, M. W. Peto—equal), I. M. Skinner, H. F. Paull, F. Mainwaring-Johnson, M. J. Scammell (W. D. Humphries, F. S. Boyd—equal), D. F. Graham, G. V. Grundeen (B. M. Crause, K. Creelman, B. D. McLaughlan—equal), (C. A. Brewster, M. R. Abbott—equal) M. Eremenko, (M. F. Brouse, R. A. Gray, E. J. F. Howe—equal), (E. R. Densham, E. M. Sutherland—equal), (E. M. Barr, E. C. Sewell—equal), Sister Pierre-Julien, G. M. Pemberton (M. M. Allen, J. W. Goode, C. A. MacKenzie—equal), P. K. A. Smith (O. H. Melneczuk, J. Sinclair, V. R. Wallington—equal), (M. L. Lyle, R. A. Moran, L. E. Vickerson—equal), (M. E. Fraser, J. G. Teit—equal), K. L. Robinson, D. M. Pooley (E. A. Muir, N. A. Smith—equal), E. M. Bryce, E. W. Tisdall—equal), J. B. Fairley, Sister Mary Grace (S. E. Larson, C. E. Lee, L. R. White—equal), G. G. M. Livingstone, E. M. Shortreed (L. Carmichael, W. C. Wood—equal), E. M. Scagel (Helen Margaret Campbell, E. Lowe—equal), M. F. Thompson, V. M. Burman, (W. F. Abbott, M. P. Ross, F. E. Winter—equal).

Passed—Misses M. J. Blythe, F. J. Miller (R. Dawson, C. A. McDonald, E. E. Minhinnick—equal), D. L. Clayton (M. M. Beven, D. L. Elford—equal), F. M. C. Haines, M. V. E. Hayden, M. C. Knight, C. O. McTavish—equal), M. I. Blakeman (P. E. M. Blanchet, E. P. Mason, G. J.

MacDonald—equal), N. M. Murphy, P. Adair, Mrs. E. King, I. M. Gilker, R. A. Gray, M. M. Harper (J. D. Adams, D. P. Langdon—equal), M. Keefer, M. B. Stewart (J. M. Blewett, R. D. V. Richards—equal), E. Newbold, A. Sheely, F. L. Lamb (H. Arnott, R. H. Hartwig—equal), (M. Archibald, I. Berg—equal), K. F. Elliot, C. H. Armstrong, H. M. Whiteley, L. M. Geldart.

Passed Supplemental—Miss E. M. C. Jackson.

With Supplemental to Write—Miss V. E. Brown.

Vancouver: A special meeting of the Vancouver Graduate Nurses Association was held on November 6th, 1929, in the Nurses Home, Vancouver General Hospital, to meet Dr. McEachern, Chicago; Dr. Haywood, Montreal; Dr. Walsh, Chicago, members of the Hospital Survey of Greater Vancouver, in order to discuss special nursing problems in hospitals. There was a crowded attendance. A questionnaire had been sent to all members of the Association asking for replies and suggestions in order to help the Hospital Survey of Greater Vancouver in the matter.

The Association held its monthly meeting at St. Paul's Nurses Home on November 13th, 1929. There was a large attendance. The result of the ballot for a ten-hour day for Private Duty Nurses was read: 198 voted for a ten-hour day, and 4 voted against. It was then agreed that the ten-hour day committee draw up a letter for presentation before the Association at the December meeting and which shall inform the hospitals of the proposed change in hours and fees of the Private Duty Nurses, and recommending that the said change be put into force on January 1st, 1930.

The first year class of St. Paul's Hospital gave a very original and humourous programme consisting of songs, recitations and violin solos, which was thoroughly enjoyed by all.

General Hospital, Vancouver: Miss G. Fairley, recently appointed Director of Nursing at the Vancouver General Hospital, has arrived from London, Ont., to assume her new duties. Her appointment to the staff was made several months ago, following the resignation of Miss K. W. Ellis, who has been travelling in Europe since midsummer.

Miss Sewell (Toronto General Hospital), Operating Room Supervisor, Vancouver General Hospital, has returned from a trip to New York and Eastern Canada.

MANITOBA

Winnipeg: The Board of Directors of the Manitoba Association of Registered Nurses entertained at dinner on December 5th in honour of Miss Agnes Chan, following which a pleasant evening was spent in the Professional Business Women's Club Room. Since attending the I.C.N. Congress in Montreal, Miss Chan has been studying at her Alma Mater, the Women's College Hospital, Toronto. When in Winnipeg, Miss Chan was en route to China, where she will resume her duties as Superintendent of Nurses, Fatshan Hospital, South China.

On Monday evening, December 9th, representatives of the Board of Directors, M.A.R.N., the Directory Committee of the Manitoba Central Registry, the Canadian Nurses Association, and the past presidents of the M.A.R.N. since 1921, gathered together for high tea at the Nurses Residence in honour of Miss Elizabeth Carruthers, Registrar of the Central Directory for the past eight and a half years. In a brief address Miss Anne Wells, President, M.A.R.N., expressed the regret of the nurses in Miss Carruthers' resignation as Registrar, and presented the guest of the evening with a handsome mantel clock.

Winnipeg General Hospital: Mrs. Mary Layton Fulton (1908), is still with her parents in Glenholme, N.S.

NEW BRUNSWICK

Saint John: Miss E. J. Mitchell was re-elected president of the Saint John Chapter of the Registered Nurses Association at the annual meeting held in the Nurses' Home at the General Public Hospital, on September 9th, 1929, with Miss Mitchell in the chair and many members present. The gratifying reports presented showed that the year just closed had been one of much successful endeavour. Miss Mitchell, in her address as president, cordially thanked the officers and members for the hearty support they had given her. A social hour and refreshments were enjoyed at the close of the general session. The election of officers resulted as follows: President, Miss E. J. Mitchell; vice-presidents, first, Miss Ada Burns; second, Miss Kathleen Lawson; treasurer and registrar, Miss M. Fraser; secretary, Miss Agnes Sutherland. Conveners of committees: Private duty section, Miss Kathleen Lawson; "Canadian Nurse" magazine, Miss V. V. Hoyt; refreshments, Miss Margaret Murdoch and Miss Ella McGaffigan; and programme, Miss Margaret Murdoch and Miss R. Wilson. The delegates appointed to represent the Chapter at the meetings of the Local Council of Women were as follows: Miss E. J. Mitchell, Mrs. A. O. Burnham, Mrs. J. H. Vaughan, Miss L. Gregory, Miss M. Fraser and Miss Ella McGaffigan.

The Saint John Chapter, N.B.A.R.N., held a largely attended and most enjoyable bridge and dance on November 25th, 1929, when over 300 were present. Novelty dances, featuring snowballs, whistles, and ribbons, as well as several moonlight waltzes, added greatly to the success of the evening. A delicious supper was served, members of the Chapter assisting. Mrs. Leonard Dunlop and Miss E. J. Mitchell were general conveners, while Mrs. J. H. Vaughan was convener for bridge and the Misses Henderson and K. Lawson had charge of the refreshments.

The proceeds from this bridge and dance will be used towards furnishing the "Stamers' Memorial Ward," in memory of N.S. Nan Stamers, who lost her life when the Hospital Ship Llandovery Castle was sunk in June, 1918. This memorial ward will be in the new hospital which is to be built soon in Saint John.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in December, 1929, were 1,257, four less than in November, 1929.

APPOINTMENTS

Miss Elsie Swetnam (Victoria Hospital, London, 1927), as night supervisor at the General Hospital, St. Catharines, Ont.

Misses E. Brieze and B. Lowrie (1929), to the staff of the Isolation Hospital.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Mary Ingham (1916), to the Nursing staff of the Toronto General Hospital. Miss Anne Ingham (1920), in charge of nursing in the Community Centre at New Haven, Conn. Miss Jessie Watts (1921), office nurse for Dr. Beverley Hannah, Toronto. Miss Gertrude Darragh (1924), office nurse for Dr. A. P. Hart, Toronto, Miss Harriett McGeary (1924), night supervisor at H.S.C. Convalescent Hospital at Thistletown. Miss Gertrude Fleming (1926), charge of children's ward of Newton General Hospital, Newton, Mass. Miss Adair (1927), charting nurse on infant ward, H.S.C. Miss Ella Webber (1927), floor duty at Lakeside Hospital, Cleveland. Miss Elizabeth Lewis (1925), assisting in the admitting room, H.S.C. Miss Margaret Scott (1926), charge of the private floor and operating room of the Henrietta Egleston Children's Hospital, Atlanta, Ga. Miss Kathleen Chamberlain (1926), Miss Vera Watson (1926), Miss Mabel St. John (1920), private duty in Toronto.

GENERAL HOSPITAL, TORONTO: Miss Muriel Locke (1916), with the Provincial Public Health Department. Miss Mabel Sharpe (1919), superintendent of the General Marine Hospital at Owen Sound, Ont. Miss Kate Elliott (1925), assistant night supervisor in the Main Building, Toronto General Hospital. Miss Frances McGarry (1929), assistant night supervisor in the Pavilion, Toronto General Hospital. Miss Doris Taylor (1929), nurse in charge of the X-ray Department. Miss Lillian McKenzie (1928), nurse in charge of Ward H, T.G.H., and assisted by Jean Michol (1929). Miss Jean Dent (1922), head nurse of the 2nd Floor Pavilion, T.G.H. Miss Marion Markle, assistant head nurse of Ward G, T.G.H. Miss Jean Collins (1929), assistant head nurse on Ward A, T.G.H.

DISTRICT 1

LONDON: A mass meeting was called for Tuesday evening, October 22nd, 1929, in the Recreation Hall of the Gartshore Nurses Residence, Victoria Hospital, London, to hear the reports of the various hospital Alumnae associations and the Edith Cavell Chapter, on the International Congress of Nurses, held in Montreal last July.

The president of the Victoria Hospital Alumnae, Miss Della Foster, presided.

The programme of the evening included the following: A description of Montreal, general arrangements and entertainment—Miss Grace M. Fairley; Open Sessions, including banquet—Miss A. P. Evans; Round Table Conferences, (a) Nurse Education—Miss Nora E. MacPherson, (b) Private Duty—Miss Boyle, (c) Public Health—Miss Bertha Smith; Exhibits—Miss Mary L. Jacobs.

With the conclusion of the papers from the different departments, the Victoria Hospital Alumnae acted as hostesses for the remainder of the evening, which was of a social nature.

VICTORIA HOSPITAL, LONDON: The regular monthly meeting of the Alumnae was held in the Gartshore Nurses Residence on November 5th, 1929. At the conclusion of the business session, the President, Miss Della Foster, expressed to the Honorary President, Miss Grace Fairley, the deep regret of the members over Miss Fairley's resignation as superintendent of the School of Nursing and her departure for Vancouver, where she has accepted a similar position. On behalf of the Alumnae, Miss Foster presented Miss Fairley with a beautiful cloisonne vase. Numerous other delightful social events were held in Miss Fairley's honour, and on the eve of her departure the staff gathered together in the Residence, when Miss Fairley was presented with a handsome leather bag, a basket of pink roses and a book. The nursing profession and a host of others join in wishing Miss Fairley every success in her new appointment, as Superintendent of Nurses, Vancouver General Hospital.

DISTRICT 2

GUELPH: On November 13th, 1929, Miss E. Smellie, of Ottawa, Chief Superintendent of the Victorian Order of Nurses, gave a very interesting address at the Nurses Residence.

Miss Smellie outlined briefly the work of the nurses in the various districts, and stressed the urgent need for nurses to enter this field. Her most instructive address was greatly enjoyed, and a hearty vote of thanks was tendered to her.

On November 29th the Alumnae of the Guelph General Hospital gave a very successful bridge and euchre in the Common Room of the Y.W.C.A.

DISTRICT 5

District No. 5 of the R.N.A.O. held its Fall Meeting in Toronto on November 30th, at the Academy of Medicine.

Round Table Conferences of the three sections were held from three to five in the afternoon, with a combined attendance of about seventy-five.

The Public Health Section, under the chairmanship of Miss Aileen Riordan, discussed "Practical Field Work for the Student in Public Health," and papers were presented from the point of view of the university, the hospital, the contributing organisation, and the student.

Miss Nettie Fidler, of Toronto General Hospital, arranged for the Nurse Education Section some very interesting papers on the subject of "Ward Teaching".

Miss Clara Brown reported a very interesting discussion in the Private Duty Section, following papers on "Private Duty Nursing" and "Hourly Nursing".

The combined business and educational meeting held in the evening was, owing to the severity of the weather, rather disappointing from the point of view of attendance. There was discussion of plans for the annual meeting of the R.N.A.O. in Toronto next April, as guests of District No. 5. Miss Kate Mathieson is Convener of Arrangements, and Miss Annie Dove, of Exhibits.

Those fortunate enough to be present enjoyed Dr. Fitzgerald's address dealing with the "Place of the Connaught Laboratory in the Community," and thought the address might well be presented as a topic for a larger group, as the R.N.A.O.

The speaker gave a most interesting history of the development of the Connaught Laboratories, showing lantern slides of early days in the coal bunkers in the Medical Building at the University of Toronto, in contrast to the modern and splendid rooms now occupied in the School of Hygiene.

General Hospital, Toronto: Mrs. Hennessy (Irene Forbes, 1923), has left the staff of the Toronto General Hospital, and is nursing in the Red Cross Hospital, Kirkland Lake, Ont.

Miss Grace Delahay (1923), is at the Rockefeller Hospital, New York, doing floor duty.

Miss Viola Henderson (1918), and Miss Emily Ferguson (1923), are doing special duty at Harbour Hospital, New York.

Miss Grace Charles (1916), has left her position at the T. Eaton Co., and is taking the Public Health Course at the University of Toronto. Miss Louis Curtis (1926), is taking the same course, and Misses Lorine Chute (1922), and Esther Strong (1922), are taking the Administration Course.

Miss Florence Thompson (1928), was in Toronto from her home in Newfoundland.

The engagement is announced of Norma M. Byrnes (1928), to R. Douglas Fleck, the wedding to take place early in March.

Hospital for Sick Children: Miss Marjorie Russell (1923), has resigned her position as Charge-Nurse of Children's Ward in Montreal General Hospital, and is spending the winter in Toronto with her parents, who are home on furlough from India.

Miss Frances Fraser (1903), has gone to California via Panama Canal for the winter with friends.

Miss Winnifred Hudson (1927), has resigned her position as nurse in charge of the Infant Ward on account of ill health, Miss Edith Wilson (1927), succeeding her.

District 7

The regular meeting of District No. 7, R.N.A.O., was held in the Nurses Residence, Kingston General Hospital, on November 18th. Owing to the inclemency of the weather the attendance was small. Though small, it was a very enthusiastic meeting. Group Nursing was the important subject of discussion. After the meeting tea was served by the staff of the Hospital.

District 8

Miss Rita Follis (Ottawa Civic Hospital, 1929), relieved on the staff of the Cottage Hospital, Pembroke, during the summer.

On Wednesday evening, November 27th, the Nurses' Alumnae Association of the Ottawa General Hospital held a very delightful dance at the Chateau Laurier. Attended by several hundred of the Alumnae members and their friends, the evening proved to be most enjoyable. The guests were received by Mrs. Peter Heenan, wife of the Minister of Labour, Mrs. C. A. Young, Mrs. J. C. Wood, Mrs. C. L. Devitt, and Miss Florence Nevens, President of the Alumnae.

The committee in charge of arrangements, to whom most of the success of the evening was due, was composed of Miss Victorine Bellier, general convener, assisted by Mrs. A. A. Poulton, and the following: Mrs. Victor Stanley, Mrs. Latimer, Misses Vialo Foran, May Macpherson, Berenice McInich, Albertine Lapointe, Marguerite Munro and Juliet Mobert.

QUEBEC

Homeopathic Hospital, Montreal: Graduation exercises were held on Friday, November 29th, 1929, in the Nurses' Home. Seven nurses received their medals and diplomas. They were: Misses A. Wyatt, E. Boa, G. Hutchinson, I. Hicks, E. Burns, H. Markell and E. Bockus. The Honour Pin was awarded to Miss G. Hutchinson. A dance was held in the evening for the graduates and their friends.

Miss J. Coyle has returned from Scotland, and is in charge of the Out Patients' Department.

Miss T. J. Whitmore has resigned from the staff, and is doing private duty nursing.

General Hospital, Montreal: Recent Appointments: Misses L. Bateson and M. Mathewson to the staff of the Childs' Welfare Association. Misses J. Dunlop, Shields, Perry, Holleenback, McQueen, to staff positions at the Womans' General Hospital. Miss Conrad Kent to staff position at Alexandra Hospital. Miss Charlton has been appointed Instructor of Practical Nursing at the Graduate Hospital, University of Pennsylvania, Philadelphia. Miss G. Vass has accepted a position as Assistant Supervisor at the Brightlook Hospital, St. Johnsbury, Vermont.

The many friends of Miss Mabel Holt will be delighted to hear that she is now convalescing at Compton, Quebec, after being a patient in hospital.

The November meeting of the Alumnae brought out many of the older graduates to hear Dr. H. Lafleur, who gave a most instructive talk on Tuberculosis. A very pleasant social hour was held after the meeting.

SASKATCHEWAN

City Hospital, Saskatoon: The usual meeting of the Alumnae was held in the form of a masquerade party at the Nurses Home, on October 22nd.

Miss Della Eamen (1928), has returned from Montreal, where she spent a month observing in the operating room of the Royal Victoria Hospital.

Miss Grace Law spent two weeks in Regina.

Miss Elsie Munro, of the Children's Hospital, Winnipeg, has accepted a position in the City Hospital as supervisor of the children's ward.

Grey Nuns' Hospital, Regina: On November 2nd a meeting of the Alumnae was held at the home of Mrs. Smith, and plans were then made for the holding of a bridge which was held in the latter part of November. Christmas parcels were sent to members of the Alumnae suffering from Tuberculosis.

The annual meeting of the Alumnae was held on Dec. 13th, 1929. The following officers were elected for 1930: President, Miss M. Anderson; Vice-Presidents, Misses I. Irons and M. McGrath; Secretary-Treasurer, Miss S. Gervais. Membership Committee: Miss E. McQuatt; Sick Visiting Committee, Misses I. Irons, E. Morton and B. Connaughty. "The Canadian Nurse" representative, Miss E. Snelgrove.

The resignation of Mrs. Grant Lewis as president during a most successful year for 1929 was accepted with regret.

It was decided to contribute $50.00 towards the purchase of an electric toaster for the hospital, and $20.00 towards pictures for the Alumnae Ward in the hospital.

Miss E. Murphy has returned after a long absence through illness.

C.A.M.N.S.

Montreal: The Montreal Association of Overseas Nursing Sisters attended the Armistice Services, following which a wreath was placed on the Cenotaph by the President, Mrs. S. Ramsey.

The first annual dinner of the Association was held on November 11th, when Col. J. T. Clarke, C.B.E., M.C., D.M.S., M.D. 4, recently appointed D.G.M.S. for Canada, and Mrs. Clarke were the guests of honour. Poppies adorned the tables. The toast to His Majesty the King was proposed by Miss N. Enright, vice-president, to "Absent Friends," by Miss Frances Upton; and Mrs. W. N. Petch proposed a silent toast to "Comrades who have gone to the Great Beyond." Mrs. Stuart Ramsey, president, presided and introduced Colonel Clarke, who gave a short talk on "Reminiscences of the War." Seventy-five guests were present.

Saint John: The Saint John Overseas Nurses voted to join the National Overseas Club when it held a short business session on November 12th at the residence of Mrs. W. J. McMillin. It was also decided to hold a series of bridges to raise funds. The annual meeting will be in January. The chief events of the evening, dinner and bridge, were most enjoyable to the large number present. At dinner, the poppies were a very effective and suitable decoration.

A wreath was placed on the War Memorial on Armistice Day, by Nursing Sister Ada Burns, for the local Chapter of Registered Nurses.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

CATTARACT—On November 22nd, 1929, at Toronto, to Mr. and Mrs. Cattaract (Evelyn Cameron, Toronto General Hospital, 1922), a son.

CLOW—On June 15th, 1929, at Brockville, to Mr. and Mrs. Harry Clow (Pearl Bell, Brockville General Hospital), a daughter.

FAULKNER—On June 20th, 1929, to Mr. and Mrs. Emerson Faulkner (Gladys Baker, Cornwall General Hospital, 1920), a son.

FINDLAY—On May 27th, 1929, at Brockville, Ont., to Mr. and Mrs. Earl Findlay (Minnie Winters, Brockville General Hospital), a daughter.

FOSTER—On November 4th, 1929, at Owen Sound, to Mr. and Mrs. S. Foster (Mrs. Ellen Clifford), a daughter (Mary Elizabeth).

GRANT—On November 5th, 1929, at Toronto, to Mr. and Mrs. George Grant (Anna Foote, Hospital for Sick Childrent 1925), a daughter.

GRANT—On November 25, 1929, at Vancouver, to Mr. and Mrs. Grant (Dorothy Patchett, Vancouver General Hospital, 1925), a son.

McCULLOCH—On November 27, 1929, at Vancouver, to Capt. and Mrs. McCulloch (Gertrude Murray, Vancouver General Hospital, 1922), a son.

McGREGOR—Recently, at Regina, to Mr. and Mrs. J. McGregor, a son.

McLENNAN—On October 30th, 1929, at Brockville, to Mr. and Mrs. Jack McLennan (Lou Edna Barrington, Brockville General Hospital), a son.

MATES—On July 28th, 1929, at Brockville, to Mr. and Mrs. George Mates (Mabel Bradford, Brockville General Hospital), a daughter.

MILLER—On August 22nd, 1929, at Brockville, to Mr. and Mrs. Kenneth Miller (Belva Purvis, Brockville General Hospital), a son.

RUDOLPH—On October 27th, 1929, at Toronto, to Mr. and Mrs. Rudolph (Florence Scott, Isolation Hospital, Toronto, 1926), a son.

SANGSTER—On July 4th, 1929, at Cornwall, to Mr. and Mrs. George Sangster (Ida Sangster, Toronto General Hospital), a daughter.

SIBBET—Recently, at Regina, to Mr. and Mrs. R. Sibbet, a son.

MARRIAGES

BAKER—BARKER—On September 10th, 1929, at Toronto, Dorothea Barker (Hospital for Sick Children, 1926), to Dr. Stanley Baker.

BASHFORD—SCOTT—On October 19th, 1929, Mai Scott (Isolation Hospital, Toronto), to Fred Bashford.

BEATTY—GREIG—On October 15, 1929, at Owen Sound, Effie Greig to Reginald Beatty, Jackson, Ont.

BRODIE—SHEARER—Recently, at Carmangay, Alta., Elena L. Shearer (Calgary General Hospital, 1929) to Dr. I. H. Brodie. Dr. and Mrs. Brodie will reside at Calgary.

BYERS—WHITE—In October, 1929, Irene Byers (Isolation Hospital, Toronto, 1928) to R. White.

CHEYLESMORE—SUNDBERG—On July 25, 1929, at Vancouver, Pearl Sundberg (Vancouver General Hospital, 1927, to Lord Cheylesmore.

CLUTE—FISHER—On November 23, 1929, at Philadelphia, Alice Leonore (Nora) Fisher (Kingston General Hospital, 1917) to William Carnie Clute, of Staten Island, New York.

CROSTHWAITE—CLINE—On November 14, 1929, at Hamilton, Mary E. Cline (Hamilton General Hospital, 1928), to Russell Crosthwaite, Hamilton.

DUNN—YOHN—On October 10, 1929, at Montreal, Rosalind Yohn (Grant MacDonald Training School, 1928) to George C. Dunn, Montreal.

FIELD—ARMSTRONG—In August, 1929, Eleanor Armstrong (Hospital for Sick Children, 1928) to Alan Field, Cobourg, Ont.

FRAIN—RAND—On September 5, 1929, at Iroquois, Ont., Doris R. Rand (Cornwall General Hospital, 1929) to Maurice Frain, La Tuque, Quebec.

GIBBS—POFF—On July 11, 1929, at Montreal, Amy Poff (Grant MacDonald Training School, 1928) to Harry Gibbs, Montreal.

HENRY—LEWIES—On July 17, 1929, at Thamesville, Ont., A. M. Lewies (Victoria Hospital, London, 1925) to Dr. S. G Henry. At home, London, Ont.

KNOWLES—WINTERS—On November 5, 1929, at Ottawa, Gladys Winters (Ottawa Civic Hospital, 1929) to George Knowles, B.S.A., Ottawa.

MAWSON—JACKSON—On November 16, 1929, at Hamilton, Dorothy Jackson (Hamilton General Hospital, 1926) to Charles Mawson, Hamilton.

MILLER—MacDERMID—On August 7, 1929, at Martintown, Ont., Jessie MacDermid (Cornwall General Hospital, 1927) to Lawrence Miller, Toronto.

PHILLIPS—LEWIS—On November 9th, 1929, Violet Lewis (Ross Memorial Hospital, Sydney, N.S., 1926) to William Phillips. At home, Truro, N.S.

RATHBUN—BRETT—On December 7th, 1929, in Nova Scotia, Nita Rathbun (Toronto General Hospital, 1922), to J. Brett.

ROSEVEAR—MATHIAS—On October 16, 1929, at Fort William, Dorothy Mathias Winnipeg General Hospital, 1929) to Alfred B. Rosevear, Winnipeg, Man.

ROWE—SHOULDICE—On June 29, 1929, at Ottawa, Freda Shouldice (Cornwall General Hospital, 1926) to Carman L. Rowe, Maxville, Ont.

SHEPHERD—THORNTON—On October 30, 1929, at Toronto, Ada E. Thornton (Galt General Hospital, 1914) to Stanley Shepherd, Cobalt, Ont.

TAYLOR—JOHNSTON—On November 28, 1929, Bessie Johnston (Saskatoon City Hospital, 1929) to John Taylor.

TEEKS—WOOD—On September 28, 1929, at Toronto, Dorothy Wood (Hospital for Sick Children, 1926) to Walter Teeks, Peterboro, Ont.

TODD—HEAGLE—On May 20, 1929, at Brockville, Ont., Luella Heagle (Brockville General Hospital) to Jack Todd.

VEITCH—COOK—On October 31, 1929, at Sarnia, Ont., Ila May Cook (Ottawa Civic Hospital, 1928) to T. Elgin Veitch, Ottawa.

WILSON—LEDINGHAM— On November 20, 1929, at Vancouver, Eula Ledingham (Vancouver General Hospital, 1927), to Marvin Wilson.

WRIGHT—MAYOR—On October 3, 1929, at Toronto, Marjorie Mayor (Hospital for Sick Children, 1925) to Bertram Wright, Stroud, Ont.

DEATHS

DARWENT—Recently, as result of a motor accident in Toronto, May Darwent (Grant Training School, 1924).

FISH—On November 19, 1929, Florence Fish (Hamilton General Hospital, 1923).

McCULLOCH—On November 19, 1929, at Prince Albert, Sask., Betty Brown McCulloch, infant daughter of Mr. and Mrs. Mervin E. McCulloch (Marion S. Brown, R.N.).

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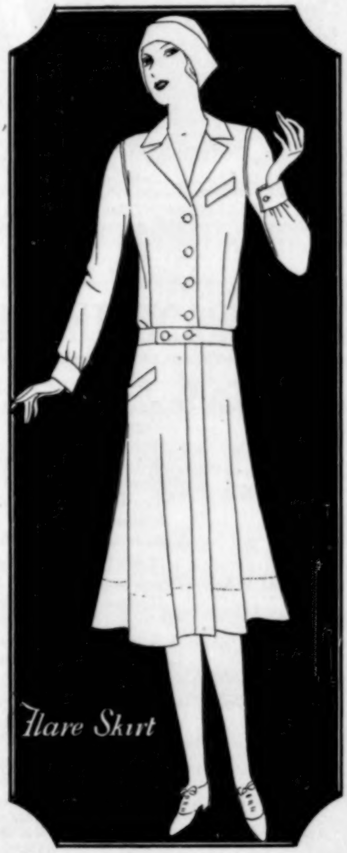

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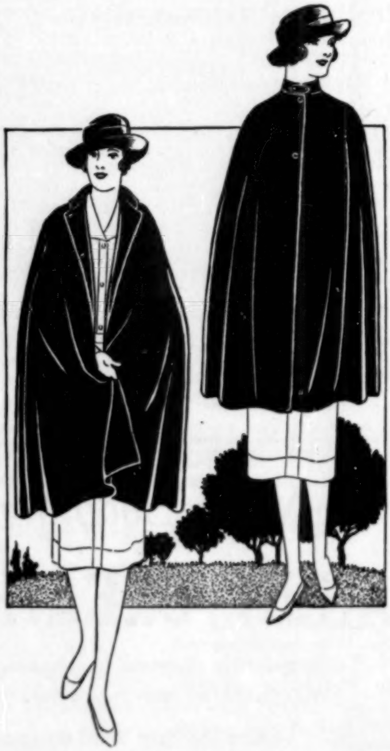

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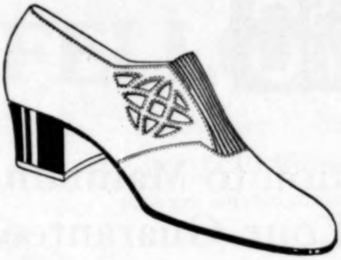

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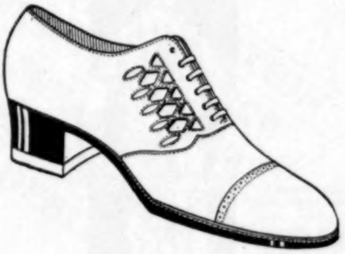

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